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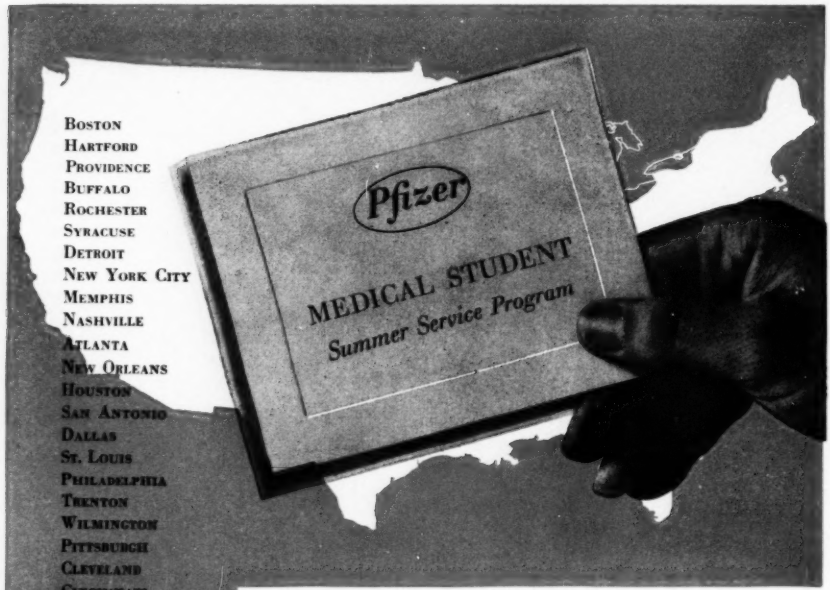

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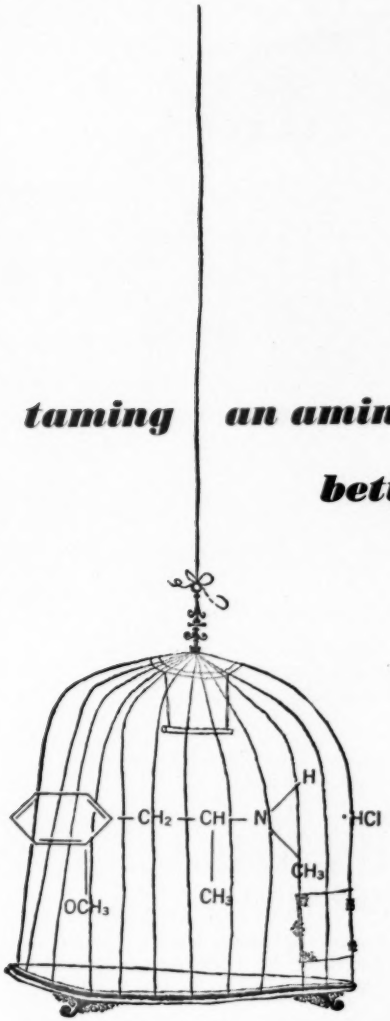

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1. Dennison, A.D.: *Jour. Med. Soc. New Jersey*, 46:139, Mar., 1949.
2. Saslaw, M.S.: *Jour. Florida Med. Assn.*, 34:657, May, 1948.

A SMOOTHER READJUSTMENT of the internal environment of the climacteric patient may be anticipated through hormonal replacement (with conjugated estrogens, equine).
Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95, 1943.

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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. *142*:806 (Mar. 18) 1950.

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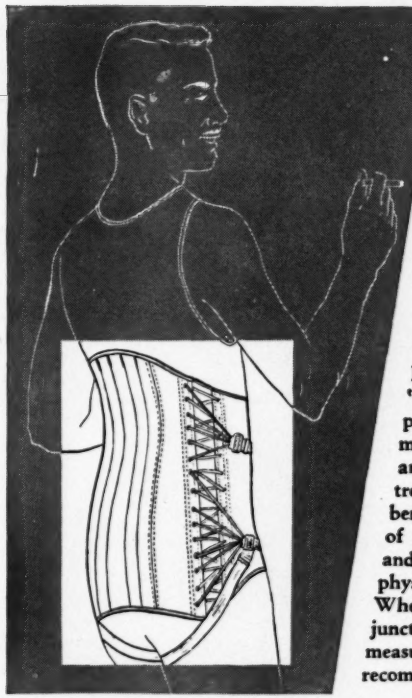

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An Orthopedic Surgeon* in writing on the treatment of lumbosacral disorders in his book Backache and Sciatic Neuritis states as follows:—"Every patient should be given prolonged conservative treatment before radical measures are considered. Non-operative treatment consists of recumbency in bed, the application of support (adhesive strapping and belts of various types) and physical therapeutic measures. When backache at the lumbosacral junction is uncontrollable by such measures, a fusion operation is recommended."

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**Philip Lewin, M.D., F.A.C.S.*
Backache and Sciatic Neuritis,
Chapter XXXIX, Page 580
Published 1943 by Lea & Febiger, Philadelphia

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REFERENCES:

1. Bicknell, F. and Prescott, F.: The Vitamins in Medicine, 2nd ed., Heinemann, 1946.
2. Dunnigan, W. M. et al: Ohio J. Sc. 44:123, 1944.
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5. Jolliffe, N. et al, ed.: Clinical Nutrition, F. B. Hoeber, 1950.
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7. Sherman, H. C.: Chemistry of Food and Nutrition, 7th ed., Macmillan, 1946.
8. Spies, T. D.: J.A.M.A. 122:497, 1943.

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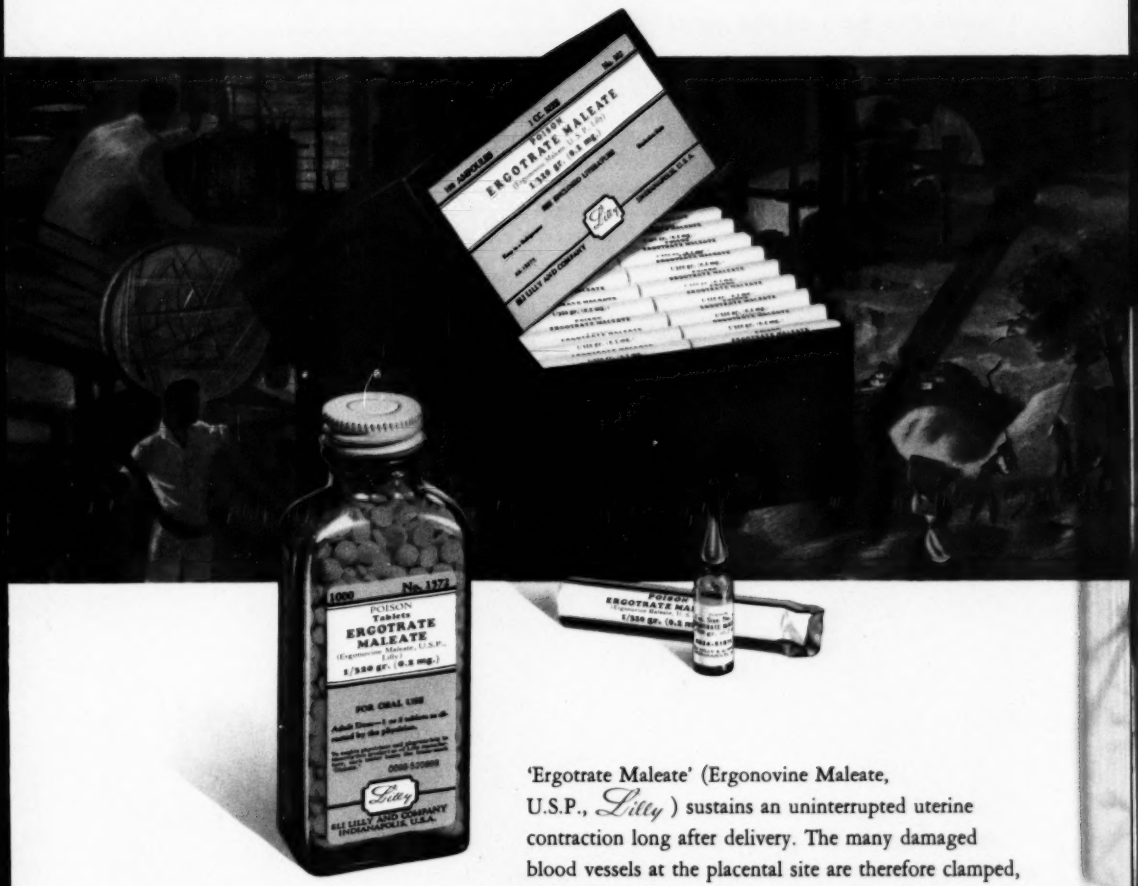

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PREVENTIVE PSYCHIATRY IN DELAWARE

M. A. TARUMIANZ, M. D.,*
Farnhurst, Del.

It is true that persons begin life with certain inherent traits and tendencies. Given a normal physical body, an individual life is composed of psychological traumas when anything occurs in the life pattern which radically differs from the average pattern. It is entirely within the realm of possibility that the process of being born is an important psychological event in the life of the child. The mere process of birth is the first human important experience which the organism must meet and it is accompanied by a certain amount, or I would rather say, a considerable amount of physical discomfort. After birth, the child must perform, without aid, certain primitive acts in order that life may be sustained. Instinctive and reflex as these acts are, they are, nevertheless, a vital change in the life pattern. Interesting as this is from a speculative viewpoint, we do not know what effect, if any, this possibly terrifying procedure of being born exerts on the development of the child. I am, of course, eliminating permanent physical birth injuries which are often the cause of maladjustment as well as difficulties due to organic diseases of the brain. From our present knowledge, we know that we have at birth a living mass of protoplasm which can be markedly affected by its environment and which is exceptionally imitative and suggestible. We cannot definitely state which characteristics are inherited and which are not. We do know that certain physical traits are present which have been definitely transmitted from the parents and we are reasonably sure that the degree to which a child may be developed intellectually is also present. Beyond this all factors of inheritance are theoretical.

*Superintendent, Delaware State Hospital and Governor Bacon Health Center; Director, Mental Hygiene and Child Guidance Clinics; State Psychiatrist.

In view of this fact, it is entirely possible that the child's adult behavior depends largely upon its early environment.

Early in life, the maternal role is of greatest importance. By the maternal role, we mean the individual who has the direct care of the child and not the physical relationship. The child shows most markedly its affection toward the mother in early years and it is natural since she is the course of the supply of food and provides body comforts. Towards her he looks for that security which is so necessary to the development of the healthy adult. This excess emotional attachment to the mother is not due to a personal relationship and is not an individual attachment since the infant would have the same feeling toward any person who cared for its immediate needs. The very young child needs very little attention beyond care of its immediate needs of producing physiological comfort in care and feeding. There is great danger in over-attention at this age, particularly if it is a first or only child, since the mother is often lonesome and derives pleasure from playing with the infant; also her natural pride leads her to parade her baby before others and to attempt too early to push it intellectually. The mother must remember that the child is not a toy. Over attention, even in infancy produces a demand for a continuance of such as well as producing a false feeling as to the importance of one individual in the group relationship of later life. Moreover, if other siblings arrive, the resulting trauma is more difficult to bear since that feeling of maternal dependence with its accompanying sense of security is so strong that the advent of another child produces a feeling of insecurity, if there is a marked change in the amount of attention which has been received. This often leads to a jealousy and unhealthy rivalry of siblings which may become a serious problem in the adjustment of the child and may produce marked behavior diffi-

culties. The need of a feeling of security is so essential throughout the entire development of the individual that care must be taken not to endanger it at any time. The early feeling of insecurity may produce and often does, an adult who fails to reach the highest possible development because of a fear of giving up even the slightest amount of security which is present in order to realize higher ambitions. The feeling of rejection which a child must experience when it has received an excess of early attention which must later be lessened or under some circumstances entirely disposed, brings into play one of the fundamental instincts, that of self-preservation. The pressure caused by over activation of this instinct must have release, the manner of obtaining this release being based on the attitude of the parents, particularly the mother in early years of life. If the child is aggressive he may attempt to physically harm the object which has endangered the fundamental feeling of security, temper tantrums may result and become a permanent part of the picture, if desires are gratified by them. Stealing, running away or other attention gaining mechanisms may be used and may become a permanent part of the personality picture, developing almost habitual aspects. If the child is submissive, his behavior may be all that could be desired but there will be an anti-social reaction in the form of withdrawal and abnormal phantasy formation. In the more extreme cases and fortunately rare ones, there may be attempts of self destruction. Suicide may be an attention gaining device since some children do not appreciate the meaning of death and are merely impressed by the amount of sorrow and attention surrounding the death of the individual. In this case, it is an aggressive act, its aim being to secure attention as well as to inflict injury to that individual who has threatened one of the essential needs of the organism, a feeling of security.

It is important that resistance towards adversity must be built up early in the life of the human organism when pliability of behavior is still present. Thus with each generation it becomes ever more necessary to train a child to meet frustrations which are bound to occur with increasing intensity.

Paternal role in early life of the child is frequently of too little importance. The child does not recognize the position of the father in the family group since his contacts with him are too slight. He does not recognize the essential relationship which exists until he is considerably older. Depending upon his disposition, he may be either a playfellow or an individual to be feared. The affection existing between the father and child is not as strong as that of the mother in that the greater part of the father's life is spent outside of the home. It is probably true that the same maternal relationship will exist when the mother is in business and the training of the child is left in the hands of hired help. However, the relationship between the parents in the home may have a definite and lasting emotional effect. The combined parental roles is of great importance in child psychology. Too often, one parent will show sympathy when the other has been attempting discipline. In studying the personality of the parents, this often is found to be based on a play for the child's affection. The father may reject the child because of jealousy of the attention which it obtains from its mother. More often the child is jealous of the father because of the attention which is given him when he arrives in the home. The mother who has been over-demonstrative during the day changes her attitude on the arrival of her husband and gives him the attention which the child feels rightfully belongs to him. This jealousy may cause the same behavior reactions which we find occurring in jealousy directed toward other siblings. Too often, the parents project their own unfulfilled wishes and desires into the child, in spite of the child's inherent abilities. They attempt to make of him what they would liked to have been.

On entering school the problems become more complex as the control of home is loosened and the child begins to learn that there are different standards as to what may be considered acceptable or non-acceptable behavior. These depend primarily on two definite factors, economic and social and intellectual endowment. In considering the child who is of normal intelligence we must recognize the fact that due to financial status of the family if it be in the lower group, there are certain opportunities which that child cannot have.

There are also certain educational limitations. It may be necessary for the child to leave school before completing the upper grades.

The wisest parent allows a child, upon approaching adolescence, to have full insight into the possibilities which are at his disposal. He gives him a clear understanding as to how much he can do for him. At the same time he encourages him to use his own initiative to progress further. On the other hand, the child from the home which is better equipped financially, should be trained to recognize that money as such is of a material nature. He should be taught to appreciate not the financial standing of his school group but the inherent character of the children with whom he associates in the classroom. To broaden his own understanding of life, he should be encouraged to pick his friends on a basis of character and individual achievement, rather than on the purely material basis of financial standards.

We all recognize the fact that all children are not endowed equally intellectually. It is essential that the parent recognizes the ability of the child and that he does not mistakenly encourage the child to go into some field for which he does not have the proper intellectual capacity and the proper type of personality. Adjustment implies — fitting in, adopting to change and relating oneself appropriately to others. Adjustment has personal and social aspects. The personal phase is based upon various emotions that determine behavior while social refers to the rules of society.

The ability to conform to social rules and requirements is important.

The conflict of the parent, the frequent accusations and hostile motives, all the bitterness and competition for child's favor, act as a psychological poison.

The child's greatest need is to have an adequate picture of family relations as a guide to his own future life. One of the most common ways of responding to difficulties and frustrations is through escape which may be an attempt to evade responsibility. Such persons are usually unable to measure up or carry out what is expected of them. Usually the aggressive child makes a determined effort to affect an adjustment while the fearful, timid child is not actively and seriously attempting adjustment. The withdrawn child is in need of more help than the aggressive individual. Though, sometimes withdrawal can be considered a kind of adjustment because the shy retiring person is unable to compete with others and retreats because he fears becoming involved in a situation that will be threatening. This type of withdrawal is very common in children between the ages of five and eight years of age.

It is obvious that adult - child relationship is of major importance because the child imitates, copies and strives to emulate and admire the adult. Therefore, the parent and teacher must take an inventory of themselves and be aware of what they really are as persons. The family should provide the child with a desirable status in the community and belongingness in the group and much needed affection and love.

Although mental handicaps and social maladjustments are of equal importance, the subject is fairly recent and the information regarding such conditions is new so that knowledge concerning the symptoms of such conditions is not as general, often resulting in an improper handling or ignoring of the problem until permanent crippling results, thereby handicapping the individual for a satisfactory social adult adjustment.

Until those trained for teaching learn to recognize each child as an individual and not merely as one of a group of thirty or so children, it will be impossible to successfully adjust the problems. It is also of supreme importance that the one in charge be familiar with the motivation preceding such conduct disorders.

These environmental conditions, since we know the cause, can often be readily alleviated without much difficulty if the parents will face the situation and help the teacher in her efforts with the child. There are, however, behavior manifestations for which the cause cannot be found in the home environment. These are of a more serious nature and as the child grows older—become more serious problems. Such conditions are usually the result of feeling of insecurity and inability to establish recognition of its ego.

Security is not a constant situation which does not vary with each individual; it depends

greatly upon the status of life in which a certain person has been reared, upon the community in which he lives, and upon the training which he had received; in a broader sense we may feel that it also depends upon the generation in which the individual is living.

It is true that the human individual is highly adaptable and may readily change from one given situation in life to another, the greatest harm being done by the abruptness of the change rather than the actual end results of that change. There are certain types of individuals who from any inherent feeling of inferiority are never at rest with their environment but who always feel the presence of some impending tragedy.

We have before us one of the essential factors in preventive work of mental conditions—the necessity of giving to every individual a sense of security in his environment. It is the duty of all thinking people to realize that food and shelter and various technological gadgets are not the only necessities of life, but each individual must have an opportunity of completeness in his mental and spiritual life. Each individual should have the satisfaction of feeling that he has obtained security through his own efforts. Society should see that each individual has this opportunity.

Therefore, in order for the individual to achieve successfully his goal in life he must have surroundings which can help him to withstand the daily shocks and blows of his environment. To learn the application of his native talents he has to have guidance and direction of his parents, teachers and others who become his immediate environment.

In recent years we have become increasingly aware of the problems of mental health and mental illness. We also recognize the fact that it is necessary to go beyond the problem of the acutely ill for the purpose of prevention. In other words we are concerned now more about mental health of the so-called normal people.

It is true that we have to make all the necessary provisions for early treatment of the recognized acutely mentally ill and that such care and treatment should be established adequately in all public mental hospitals as well as in large general hospitals. However, mental hygiene activities should go into the routine of kindergartens, public schools, industry, the public sphere of activities, and the homes of the families.

When a child is found, through various facilities such as clinics, schools, family physicians, pediatricians, various social agencies, church, juvenile and family courts and others interested in the welfare of the child, not responding to extra-mural treatment, he should be hospitalized in a psychiatric preventive center where a well organized team, composed of psychiatrists, pediatricians, psychologists, social workers, educators and others, will tackle the problem intelligently and understandingly.

While the child is under treatment in the Center, plans for his future socialization in the community must be worked out by the staff. Such a planning program should incorporate various social outlets in addition to home, school and church.

Having the above philosophy in view, the state of Delaware established the Governor Bacon Health Center primarily as a psychiatric preventive hospital for children. The state has been very generous and has appropriated sufficient funds for such a state-wide activity.

Let us see what has transpired between the opening of the Governor Bacon Health Center from November 1948 until the first of July 1951. What actually has been accomplished?

Since that time in November 1948, 222 children have been admitted to the Governor Bacon Health Center as maladjusted. Of these 164 were boys and 58 girls. They ranged in age from 4 to 16. Of the 164 emotionally disturbed boys, 37 have benefited from their therapy and experience in group living to the point where they could be discharged as improved to their own homes. Fifteen other boys improved sufficiently to be discharged but, because their home situation was such, they could not be discharged to their homes but had to be placed in a foster home situation. The total number of boys then who have improved as a result of their experiences and therapy is 52 (37+15) which means 31.7% of the total number of emotionally disturbed boys who have been at the Governor Bacon Health Center since its opening. Of the 58 girls who were here, 12 were returned to their own homes

improved. An additional 8 girls improved sufficiently to go to foster homes. This represents 34.4% of the total girls treated at the Governor Bacon Health Center since its opening.

The United States government informs us that an adult, in his lifetime as a citizen, averages fifteen thousand dollars worth of taxation. If we have rehabilitated these children permanently as healthy citizens of Delaware and the United States, we have more than justified the expense of the Governor Bacon Health Center. It remains to be seen how many of these children maintain their improvement, avoid future difficulties, and remain as healthy citizens.

Since its opening until present, 136 children were admitted as social problems. Of these 74 were boys and 62 girls. This means that they were sent to the Governor Bacon Health Center for care until a home could be provided for them.

In the same period of time 13 children were admitted who were considered psychotic and pre-psychotic. Of these 12 were boys and only one, a girl. It was necessary to transfer only two of these to the State Hospital. Five of these children were well enough to go to their own homes. This represents 41.6% of the total.

In the rheumatic fever section for convalescent children, 25 children have been admitted in this period of time. Of these 19 were boys and 6 girls. Fourteen of these 25 were discharged to their home, improved, representing 56%.

In the convulsive section we have received 44 epileptic children of whom 24 were boys and 20 girls. Thus far 5 of the total have been discharged to their family as improved, representing 11.4% of the total. We feel that this is not a true representation of improvement in epilepties because of the type of patient seen in our particular group. The incidence of mental deficiency with epilepties in our particular group was very high.

In our crippled children's section we have had a total of 79 patients of whom 47 were boys and 32 girls. They represented varying diagnostic category. They have been given intensive care representing general nursing care, speech therapy, physical therapy, special schooling, and surgery. Thirty-three of the total have been discharged improved, constituting 41.8% of the total.

We are hoping to be able to show in a few years the justification for such an expenditure on the part of the taxpayers. It is well known that the maladjusted children of today are the serious liabilities of the future.

DIAGNOSIS AND TREATMENT OF ANXIETY STATES*

JOSEPH HUGHES, M. D.**
Philadelphia, Pa.

INTRODUCTION

Public Health Surveys based on Selective Service Data from World War II estimate that there are in the United States 8,500,000 emotionally disturbed individuals who are potential psychiatric patients[1]. Other studies show that 1,134,000 children have behavior disorders[2]; 750,000 adults are chronic alcoholics while 11,998,000 are addicted to the excessive use of alcohol.[3] In the field of chronic psychiatric illness, statistics show a census of 938,000 patients in the mental hospitals of the United States[2] with a yearly admission rate of 114,535 patients.[4]

Clinically it has long been recognized that before patients develop serious psychiatric disorders they experience periods of recurrent emotional distress marked by stages of increased psychic tension, lessening effectiveness, persistent functional somatic symptoms and recurrent periods of anxiety. This paper is directed towards a consideration of patient needs in this period of distress prior to the development of a psychiatric illness. It implies that early recognition of pathological anxiety and prompt treatment is the most effective means to decrease the incidence of chronic emotional illness.

Anxiety is common to all illness. When it causes a patient to seek treatment for his symptoms it is normal and protective. However, when anxiety exists without any known cause and when it results in a prolonged state of deep foreboding or fear for which the patient has no explanation, it is abnormal and pathological. Investigation of such reactions

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**Professor of Psychiatry, Woman's Medical College of Pennsylvania, Consultant at the Gov. Bacon Health Center, Delaware City, Del.

always reveals evidence of repressed emotional conflicts beneath the level of conscious awareness that are of sufficient intensity so as to give rise to the symptoms and emotional reactions of the patient.

CLASSIFICATION OF ANXIETY STATES

Anxiety reactions are best diagnosed and classified in terms of dynamics and psychopathology rather than in descriptive terms of the surface behavior and symptoms of the patient. In such a classification, the anxiety seen in a psychoneurosis is perceived as a threat by the conscious personality whereas its origin is usually found in repressed, culturally non-acceptable emotions which give rise to conflict. These conflicts are then repressed from conscious awareness and are displaced or converted into functional somatic symptoms or expressed in personality reactions characterized by withdrawal or hostility or dependency, or expressed in terms of "free floating" anxiety. The dynamics of a psychoneurotic reaction revolve around conflicts in the field of emotional communication: parent-child, sibling or group relationships.

In contrast to psychoneurotic disorders, there is little if any anxiety perceived by the patient who suffers from a character or a behavior disorder because of the patient's capacity for the uninhibited acting out of hostility or aggressiveness. Character and behavior disorders are subdivided into the following classification: pathological personality types (schizoid, paranoid, cyclothymic, antisocial, asocial, sexual deviates and addicts), immaturity reactions and emotional instability. In an immaturity reaction or in emotional instability anxiety manifests itself under conditions of minor stress and is an expression of a life long pattern of behavior. The reactions of such patients are characterized by undependable judgment, fluctuating emotional attitudes and explosive feelings.

Anxiety when it is a symptom of a psychosis manifests itself in terms of a panic reaction accompanied or preceded by chaotic, disorganized behavior and reflects gross distortion in accepted values. In a psychosis there is always evidence of personality disintegration, emotional disharmony and unpredictable mood swings accompanied by an inability on the part of the patient to be close to or effectively related to another person. Psychotic disorders are always marked by disturbance in the ability to perceive reality and by a lack of judgment and insight.

At the risk of over-simplification it may be stated that the common sources of anxiety in our present cultural pattern are: threatening infantile or childhood experiences (physical and/or emotional); poor conditioning for adult life; failure to attain life's goals (important after age 40); overwhelming environmental demands (war) and situational maladjustments.

The following factors enter into the problem of recovery: the significance, to the patient, of his conflicts; the skill of the physician as a therapist; the inherent capacity of the patient to adapt himself to threatening situations. Concerning the factor of adaptability it may be useful to know that studies on group behavior, under conditions of sudden, overwhelming stress, indicate that 25 percent of individuals show a superior capacity for effective adaptation and react with purposeful activity, 60 percent react noneffectively with random activity while 15 percent react totally ineffectively with purposeless activity. The present view is that adaptability is both psychologically conditioned and genetically determined.

TREATMENT

The first step in the treatment of anxiety is psychotherapy. Directed activities including physical exercise, occupational therapy and physiotherapy have also a role. Sedation should be employed for the relief of acute symptoms. In addition the general nutritional state and physical health of the patient cannot be overlooked. Since a main interest of this paper is early diagnosis and treatment the technique and clinical effectiveness of psychotherapy will be discussed in more detail.

Psychotherapy revolves around the doctor-patient relationship. It involves the emotional attitude of the doctor and of the patient as well as all the spoken and unspoken communications that are a part of a personal relationship. On the verbal or spoken level it involves explanation, reassurance and suggestion. On the nonverbal level it involves sharing, identification, loyalty and the growth and development of insight. A first essential is the

ability to establish a close, warm and sympathetic contact with the patient and his problems in order to facilitate the patient's capacity for communication. If the physician is defensive, authoritative or angry his effectiveness as a psychotherapist is blocked.

Consideration of the clinical results seen over a four year period in the Veterans Psychiatric Clinic at the Woman's Medical College Hospital will give some indication of the role and effectiveness of psychotherapy. The 478 patients treated during this period of time were men who had seen service in World War II. Therapy averaged one hour per week for 16 months. From a diagnostic standpoint 176 of these patients suffered from psychoneuroses, 224 from character neuroses (immaturity reactions, emotional instability) and 78 from psychotic or latent psychotic reactions (schizophrenia). Of the 176 patients with psychoneuroses 64 (36 percent) showed marked improvement (relatively symptom free, effective relationships with people); 90 (51 percent) showed moderate or slight improvement (anxiety still present under conditions of moderate stress, moderately effective with people) and 22 (13 percent) showed no improvement (anxiety present with little or no stress, noneffective personal and/or work relationships). Of the 224 patients diagnosed character neurosis only 10 (0.4 percent) showed marked improvement, 92 (41 percent) moderate or slight improvement and 122 (58.6 percent) no improvement. Of the 78 patients with psychoses 32 (41 percent) showed marked improvement, 26 (33 percent) slight improvement and 20 (26 percent) no improvement.

In another clinic staffed by the same psychiatrists a group of 50 patients have been under treatment for more than a year, suffering from severe psychosomatic disorders. None of these have made a complete recovery despite a year of combined psychiatric-medical treatment in favorable clinical circumstances. Those few patients, less than 10 percent, who have shown some lessening of their symptoms did so only after altering the situational difficulties in their home environment through the combined team efforts of the psychiatrist, the public health psychiatric nurse and the psychiatric social worker.

Considering the clinical results seen in these two groups of patients it is clear that given the same degree of skill in psychotherapy other determining factors in recoverability are: the life situation of the patient; his inner resources; the potential for softening or changing the unfavorable social factors feeding the patient's conflicts.

DISCUSSION

For the clinician to be able to successfully understand and design a treatment program for his patient he must realize that anxiety can be best relieved by communicating one's thoughts and feelings to another and by goal directed activity. From this it follows that a first therapeutic step is to encourage and permit the patient to talk himself out. From the emotional cues that develop out of the patient's productions the direction of therapy is determined. In this regard two questions must be answered: What is the patient's conflict? What steps must be taken to resolve the conflictual situation?

It is to be remembered that an anxiety state does not develop suddenly, but grows out of an intolerable accumulation of unacceptable emotional relationships throughout the lifetime of the patient. The precipitating factor should be viewed as the last event in a long train of emotional trauma.

The length of the psychotherapeutic interview must be sufficient for the patient to perceive the friendly, kindly and sympathetic attitude of the physician. Thirty to sixty minutes may be considered as satisfactory for this purpose. Each interview should be concluded in an atmosphere of mutual confidence. It is also good clinical procedure to outline a program of physical activity and a schedule for daily living that will substitute activity for indecision. The patient with anxiety is frequently blocked in his ability to communicate to his physician because of his unconscious feelings of guilt or anger directed at someone within a close family or love relationship. To facilitate breaking through this block, criticism on the part of the physician, expressed or unexpressed, is to be avoided. When this block in communication remains resistant, sodium pentathol intravenously or sodium amytal by mouth, frequently prove to be effective release agents.

In all the permissiveness practiced by the

physician during the psychotherapeutic interview, there must never be conveyed to the patient any approval of behavior that would encourage the patient to maintain his neurotic pattern. Hostile attitudes on the patient's part must be carefully appraised and analyzed. The physician should not hesitate to take an active role in helping the patient to resolve his conflicts. As far as possible the patient's daily life experiences should be used as the background for guiding him in an understanding of his problem. The patient must feel that his problems are understood and shared by the physician, the nurse and the social worker and he must feel their loyalty to his problem. This attitude of professional helpfulness and loyalty must at all times be expressed not only along friendly but also along commonsense and realistic lines.

If insight into disturbed emotional relationships is to be achieved through discussion, it must be attained through the patient's own perception of his problem. It is a shortsighted therapeutic view to believe that a patient's entire treatment should center around his relationships with his physician, and every effort should be taken to utilize the corollary skills of the psychiatric public health nurse and psychiatric social worker for creating favorable standards of health (physical and emotional) in the home and to achieve satisfactory relationships in the patient's contacts in the community and at work.

111 North 49th Street.

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DISCUSSION

DR. A. L. INGRAM, JR. (Wilmington): I would like to express my appreciation to Dr. Hughes for a most interesting and certainly a most timely review of the problem of anxiety. Abnormal anxiety, as delineated by Dr. Hughes, is being seen more and more in these times of increased external pressures in the form of international and domestic unrest. Given these external pressures in combination with inner conflicts, which are completely unrecognized by the patient, and you have a patient who is familiar to all who practice medicine, whether they may be general practitioners, internists, or surgeons.

I would like to stress the importance of the attitude of the physician in the treatment of these anxiety states. All too often, as Dr. Hughes pointed out, these patients are dismissed with the comment, "Oh, those pains are just your imagination; don't worry about them." I would like to emphasize that these people are sick. The pain of a conversion hysteria is just as real as the pain of acute appendicitis, and has a pathological background just as real as the latter. Thus, reassurance and explanation are far more beneficial than the threatening implications inherent in such a remark as quoted above.

Again it should be emphasized that many of these minimal superficial states of anxiety can be resolved without recourse to the services of the psychiatrist. This can be accomplished in many cases by the simple technique of being a good listener, which Dr. Hughes mentioned. The anxious patient is eager and many times desperate to tell his story. He needs a friend, he needs a confidant, and in the ventilating of his problem he not only dissipates some of this anxiety we are talking about but actually clarifies the difficulties in his own mind. We do not know how many malignant neurotic states are prevented by this simple expediency of listening well, but the figure can be high.

Finally, the thought occurs to me that it would be well to bear in mind the role that anxiety plays as a reaction formation to the presence of a severe disease. This again is seen in every day practice. It is what the general practitioner with many years experience takes into consideration when he treats the patient as a whole, and not just the disease.

Anxiety over illness can be a determining factor in the ultimate outcome of the disease process itself, particularly in such conditions as coronary thrombosis, hypertension, and peptic ulcer, to name a few. Indeed, the life expectancy in coronary thrombosis is directly related to the degree of anxiety present in the patient over his illness.

In the less severe forms of illness, we find

that anxiety still is a factor to be reckoned with, or although it is not perhaps related directly to the life expectancy, it is often a retarding influence in the getting well process.

DR. A. M. TARUMIANZ (Farnhurst): I hope that this masterfully presented paper of Dr. Hughes will not create any anxiety in the minds of the doctors. In primitive life we certainly didn't know anything about anxiety states. Since life in this complex world has become so intricate and so difficult, and since we have not advanced technologically from the standpoint of our brain activity to meet with these problems adequately, we are bound to go through various types of anxieties.

There are anxiety states which I consider absolutely normal in any human being. That is, unless the person is so defective that he cannot react to conditions surrounding him. Whether those conditions are of a physical nature, or emotional, cultural, or any other type, the fact remains that unless the person has been trained from early childhood to recognize his own personality, to have a concept about his liabilities and assets of his personality, how do you expect that individual to learn how to exercise his assets as compensation to his liabilities? Life itself is one of the biggest of businesses, and from that particular standpoint my only suggestion would be that we as medical men do not hesitate to consider every normal anxiety as the first step to possible serious anxiety states in the future, and possibly to frank psychotic conditions.

Therefore, Dr. Hughes' lecture was very timely. I don't think there are enough psychiatrists to assume the responsibility for all psychiatric problems which are obvious to the minds of laymen. You are general practitioners and medical men in all specialties. You are the ones who will discover the first signs of a serious anxiety state, and obviously it is entirely up to you to recognize this condition and immediately take adequate steps to overcome the difficulty.

I also believe that all general practitioners should be able in the 20th century to handle most of the psychiatric problems that don't require special attention. I hope Dr. Hughes will agree with me because otherwise I am afraid that you are expecting entirely too much from 5000 psychiatrists practicing psychiatry in the United States. I think every general practitioner is fundamentally a psychiatrist with God-given ability to understand the problems of human beings, and unless he understands them I don't think he is qualified to practice medicine.

I have learned in my forty years of medical practice one thing, that regardless of my knowledge of psychiatry and neurology and medicine as a whole, I fail my patient unless I try to be a human being and put myself in his place. The mere statement that there is nothing the matter with you is certainly not a remedy, nor is a prescription of sedatives an answer to a serious problem of human life.

May I also say at this time that we have no right to condemn the general practitioners. We as psychiatrists practice that unethical approach every day. We also deny the patient time to ventilate and purge himself, many times. So it is not only the general practitioner but the psychiatrists themselves, and I know that many of them, including myself many times, when they are dead tired and they have already seen six or seven patients, hardly have the ability to listen for an hour to a patient. Yet the patient doesn't recognize that.

So I think Dr. Hughes has presented a very fine approach on how we should deal with our patients.

I would like to ask Dr. Hughes, if I may, whether he believes that sometimes, quite frequently, after the patient has ventilated sufficiently, wouldn't he advise the general practitioners to not hesitate to go into a deeper layer of the problem and not to adhere to the superficial facade of the condition?

DR. HUGHES: I am grateful to Dr. Ingram for his critical summary of the role of anxiety in somatic disease and I am in complete agreement with him on the great need that exists to have the problem of anxiety recognized by the general practitioner at its onset so that prompt and effective treatment can be instituted.

Dr. Tarumianz raises a question of great importance when he asks to what degree should the general practitioner go in trying to bring insight to the patient? It is my belief that the general practitioner is ideally suited to enter into the process of psychotherapy and because of the rapport that exists between

him and his patient he is ideally placed to probe into the unconscious factors underlying the patient's reaction providing that he does not attempt to make any psychiatric interpretation of his findings to the patient that is beyond his own training or experience.

NEUROPSYCHIATRIC EMERGENCIES*

JOSEPH C. YASKIN, M. D.,**
Philadelphia, Pa.

I rather fear that this presentation will be an anti-climax after the three previous ones, both from the standpoint of the subject matter, and more particularly from the standpoint of the time and weather conditions. I shall therefore take the liberty of curtailing my speech and making some few remarks that may be useful to you.

The subject itself sounds a little unusual. It is so far away from what is clear-cut, for instance, coronary occlusion or the management of anxiety. I am speaking of neuropsychiatric emergencies. They should be divided into neurological and psychiatric emergencies. One wonders what emergency a dermatologist or a neurologist may have. The neurology of today is vastly different from the neurology of those days when some of my colleagues of my own age level went to school. In those days neurology was a question as to who described what disease. The professor of neurology at the university doesn't know the names of most of the diseases Dr. Spiller and Dr. Mills worried about, and I feel better since I have forgotten them.

By neurological emergencies we mean those conditions which should be diagnosed early from the standpoint of treatment so that we can prevent death or invalidism. There are such conditions which have evolved, let us say, in the last several decades. They evolved first because we recognize disease entities more clearly; secondly, because we have much better therapeutic approaches, both surgical and medical. I will refer to just a few and I will be very snappy about it.

Neurology was and should remain a branch of internal medicine. When neurology or psychiatry becomes divorced from internal medicine, they become impotent. They become dangerously impotent, and the trend these days for some psychiatrists — and I am not referring to the Delaware School — stating that it isn't necessary to be a doctor in order to be a good psychiatrist, is very false. I am quite sure that as time goes along this truism will become more evident.

There are certain syndromes in neurology that one must recognize promptly. Among these are the infections of the nervous system. When this slide was made all we had was the sulfanilamides. Now, of course, we have much better approaches than the sulfanilamides, and an early diagnosis of infections of the nervous system is important.

Some of the younger men may worry why I am so concerned about the early diagnosis of meningitis, but it is a fact that meningitis is overlooked very often even in teaching hospitals. Not so many weeks ago, an elderly gentleman was admitted with an acute gastro intestinal disturbance. It wasn't until a week later that it was discovered that he had acute meningitis complicated by hepatitis. Treatment helped a little, and after about five weeks he left the hospital in pretty good condition.

Some of these conditions are very easy to diagnose, yet many an intern, or perhaps even a surgeon, forgets to do the minimum study, namely, the study for meningeal irritation, the stiff neck. Brain abscess is becoming less frequent due to the antibiotics, but I predict that as time goes on we will have more of them than we even had before, because the antibiotics mask the underlying intracranial complications.

Spinal epidural abscess is not a common disease. When diagnosed it is readily amenable to treatment. The usual story is that of the person who comes in with weakness of the legs and pain around the waist, or lower or higher, in whom there is often a history of a boil or a carbuncle, or some other focal infection of the skin. The patient complains of pain, then he loses power in his limbs, and if you do a spinal tap, you will find that he has a partial block with a high protein, and if you do a sensory examination you will get the level without any trouble. Operation should be performed as soon as the diagnosis is made, just as you would in the case of a

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**Professor and Chairman, Department of Neurology, University of Pennsylvania Graduate School of Medicine.

perforated duodenal ulcer, or an acute perforating appendix. The results are excellent if you do it very early.

Most of the spinal epidural abscesses occur in the mid-dorsal region. I have seen them in the lumbar region and less commonly in the cervical region.

The chronic infections of the nervous system are not so important except syphilis. Syphilis — I mean neurosyphilis — still exists in Pennsylvania. Curiously, it may occur even among your best friends in whom you wouldn't dare to do a Wassermann. It isn't always easy to suspect neuro-syphilis. However, if as a part of your routine examination — and the surgeons should teach their surgical residents to do this — you just look at the pupils to see if they react to light, and take the reflexes, you might avoid all sorts of difficulties. I've seen patients who are operated on for gall bladder disease, and they always find a red gall bladder or strawberry gall bladder, but the patient continues having pains, and the real difficulty is tabes dorsalis And curiously enough, it occurs even in teaching hospitals. Only in the last four months there was a patient admitted with diagnosis of gall bladder disease, who just happened to have a touch of tabes. She was operated on before I saw her.

Trauma of the nervous system is becoming of greater importance than ever. Concussion of the brain and contusion and laceration of the brain, are some things of which every physician is fully aware. Injury to the middle meningeal artery fortunately is not very common. It is a very dreadful disease. As you all know, there is usually a clear history of trauma, a short period of unconsciousness, a longer period of lucidity, then profound stupor, often hemiplegia and death if you don't drill the hole. You don't wait for x-ray in those cases. When you make the diagnosis you ship them right up to the operating room and let the first resident that knows anything about using the Hudson drill get down there and ligate that artery.

Now, the chronic subdural hematoma is an important and common disease. Gentlemen, subdural hematoma is much more common than we think. I believe every physician should be keenly aware of the problem of the subdural hematoma. As you know, there is rarely a history of a good injury. The history usually comes after the patient recovers. The patient often complains of a great deal of headache, he is usually somnolent and restless, often screaming in his sleep with pain and may even be comatose. There is little increase in intracranial pressure, as revealed by choking of the discs, and you have to see a number of these cases before you suspect it. Let me cite some cases for you.

About five weeks ago, on a Thursday night, I saw a 77-year-old spinster with a very bad family history of heart disease and hypertension. She had heart disease and hypertension for many years. About ten days previously she fainted in the bathroom. Then she rallied and then began to complain of a little headache, and for the past three days was completely stuporous and unresponsive. Her family physician thought it was just another one of those strokes, although he didn't localize the lesion. On examination, I found a patient who was barely accessible, and quite sleepy. I was sure that she had weakness of her right hand. She had a right Babinski. I learned from the family that she didn't talk well for the last week even when she wasn't stuporous, and I found very distinct tenderness on percussion over the left side of the skull. After much arguing with her family physician, and even more arguing with the family, we had her admitted to the hospital, and at eight o'clock next morning the resident drilled a hole and found a nice big subdural hematoma on the left side. While on the operating table she began to talk, and as a matter of fact she hasn't stopped talking for three days after that.

The thing that I am describing to you now is not unusual. That is the usual thing in a subdural hematoma that is not decompensating. Of course, when one is badly decompensated, no matter how much you drill it doesn't work.

To give you an idea of the frequency of subdural hematoma, I might say that in the Graduate Hospital within 16 days we had some five verified patients. When I was an intern in the Philadelphia General Hospital I don't believe I ever knew there was a subdural hematoma. Now every stroke is thought of from

that standpoint, and there are a number of emergency procedures for these cases.

Now the operable brain lesions, the brain tumors. You might ask, why is this an emergency? Well, it certainly is, because if you diagnose the pituitary tumor early you have a useful life of anywhere from five to thirty years. If you diagnose the pituitary tumor early, before patients get fat and pale, and before they are blind, most of them will yield to ordinary x-ray treatment. Few will require decompression. But they will live on and be useful citizens for many, many years. I regard this as an emergency. When they come to us blind and dilapidated, we can't do anything for them. And pituitary tumors are 17% of all brain tumors, and brain tumors are 4% of all tumors in the body, exclusive of the uterine fibroids, about which nobody keeps any statistics. Likewise with meningiomas; 13% of tumors are meningiomas, and if you get them early enough you can prolong the life of the individual and they remain useful anywhere from 5 to 25 years.

I have under my own care a woman who came to me in the early 20's, blind and dilapidated. We managed to localize a little tumor which wasn't larger than the end of my finger. For the succeeding few years I had to send gifts to her every few years because she proceeded to give birth to a baby every year.

The same is true of the cerebello-pontine angle tumor, which is rather easy to diagnose if they have deafness in one ear. This is usually treated by politzerizing. Still later in the disease you get cerebellar signs. If you get the cerebello-pontine angle tumors early, you get good recoveries. If you neglect them, if you don't treat them as emergencies, if you forget about them, you get a lot of invalids.

So you have 17, and 13, and 8%, or about 38% of brain tumors wherein the patients can be made into useful citizens if you diagnose them soon enough.

The brain abscess problem is a rather difficult one, in a way, because it isn't always easy to diagnose. However, if you remember that brain abscesses are due to one of three major causes: (1) The infections around the paranasal sinuses and ears; (2) intra-thoracic suppuration; and (3) infection in other parts of the body. If you have a history of infection and then you have evidence of increased intracranial pressure, then you can suspect a brain abscess, and in most cases, with the aid of antibiotic therapy, we get good results.

The most gratifying patients in neurology are spinal cord tumors of the primary kind. They are not infrequent. The diagnosis of that condition depends upon symptoms of root irritation, and in the later stage, of spinal cord compression. The protrusion of the intervertebral disc has been talked about considerably and I shall not go into it.

Perhaps one of the most important diseases that one should detect early, and I assure you it is not detected early, is pernicious anemia. You needn't worry about polyneuritis. But the story is entirely different in pernicious anemia, and when you think that in a medical center such as Philadelphia we get no less than 18 to 20 cripples every year because pernicious anemia is not diagnosed early enough, it is sad.

The diagnosis of pernicious anemia does not depend on neurological findings. It is true that pernicious anemia may begin with neurological findings and that the blood count may be normal. The diagnosis of pernicious anemia depends on vague symptoms, the dysesthesia and parasthesia. We have learned not to depend on the blood count. If I want to be sure that the patient has no pernicious anemia, I at once have a gastric analysis. If there is hydrochloric acid, I don't believe I am dealing with pernicious anemia. If there is no hydrochloric acid, my next step is not only the study of the peripheral blood but a study of the bone marrow. People are brought in ambulances, pale and sometimes not so pale, and make very good progress on an anti-anemic regime.

It is particularly difficult to suspect pernicious anemia when you see an individual with a ruddy complexion. One of my residents brought his father in a couple of years ago from Washington with very suggestive formication of his hands. I told him I thought his father had pernicious anemia. He thought I was crazy. But the bone marrow was characteristic, and there was no hydrochloric acid. I heard from the son, who is in the Army now, that his father was doing very well. Another six months and he would have been a cripple.

The way to think neurologically is not who described the symptom. The way to think cardiologically is not whether the murmur is of the apex or the base or the back. Nobody gives a darn where the murmur is anyway; it's a question of what that heart is doing. I am talking as an internist now, not as a psychiatrist. Similarly, in neurology, we are not interested in who described the disease. We want to know whether there is evidence of meningeal irritation. Does the patient have something that irritates the meninges? If so, is it blood, is it pus, is it a tumor? Root pains, are just as distinct to us as, let us say, a thrombophlebitis is to an internist. Inequality of tendon reflexes always require an explanation. There must be a reason for it.

Presence of pathological reflexes—I should like to state just briefly that to be a good internist, or a good neurologist, you must not know too many signs. The neurologist who knows too many signs is not a good doctor, because a good doctor hasn't the time to explore all the signs described by people the world over. He limits himself to a few things: the pupils, the biceps and triceps, the Hoffman reflex, the knee, the Babinski. He often doesn't have enough time to do all of them, but he should. You can do even fewer, but do them regularly and you will catch a lot of this.

Evidences of increased intracranial pressure and of local brain disease—he who has a headache for a long time, even if he is a neurotic, should have the benefit of at least one x-ray study.

I should like to emphasize that the most important psychiatric disturbance is depression. I am not trying to take the glory away from Joe Hughes; anxiety is extremely important, so is elation, so is apathy. But emotional depression is something that every physician should be keenly aware of. Depression is not just a word that poets use or psychiatrists use. Depression to the clinician is just as much of an entity as the fever registered by the thermometer or the abdominal tumor that you feel with your hands, or the acute abdomen that you must operate on at once. You must learn to recognize the existence of depression whether you are an internist, a gynecologist, a general surgeon, or even a nose and throat man.

As Dr. Tarumianz discussed earlier, depressions don't have to be pathological. For instance, you and I have normal depressions. Some of you may be depressed listening to me for 18 minutes. That is a normal fluctuation. Then there is the psychoneurotic depression that Dr. Hughes talked about. Then there is the depression that one sees in dementia praecox early in the disease, as a rule, which does not last long enough.

Depression occurs in structural and chemical disease and intoxications. Depressions occur in tumors in the posterior part of the abdomen. That is very important. You don't know whether you are dealing with a neoplasm or dealing with emotion depression.

Then of course there is the manic depressive type, and lastly there is the involution melancholia, which is the most important because it occurs in the involution period of life, 45 to 55 in women, a little older in men. Second, because it hasn't a darn thing to do, so far as we know, with the menopause. It is not cured even by the most expensive products promulgated by the manufacturers. Third, it often begins with a lot of physical complaints. You think the patient is having heart disease or bladder disease or GI disease. You permit him to go on until he gets depressed and often commits suicide. Moreover, it occurs in certain types of individuals, but time doesn't permit me to go on.

It is important to recognize depression. You cannot treat depressions by treating their somatic complaints. You can give them hydrochloric acid, or liver, but it isn't going to do any good. Second, there is always the suicidal possibility. Personally, I wouldn't care if some of my patients would commit suicide — for instance, some of my schizophrenics — but I feel very keenly when a depressed patient commits suicide because most of them become well.

Thirdly, shock treatment is of benefit in the true depressions, in over 80% of the cases. Lastly, when a patient is depressed the ordinary psycho-therapy doesn't do him a bit of good. You can't encourage him, you can't guide him, you will talk to them from now

until doomsday about their early life or even about their environmental factors; they will be pepped up for a while but then when they leave you they'll say, "The doctor is a smart guy but he doesn't understand me." And he is about right, because the depressed person lives in a world of his own and he doesn't stand for a lot of nonsense.

To diagnose depression I gave you this outline. There is a family history; and the patient may have had previous mild attacks. He will tell you that he had gastro intestinal disturbance five or ten years ago, was treated for colitis and got well in nine months. He didn't have any colitis to begin with. He had an attack of depression. You exclude the primary somatic structural or chemical disturbances. These patients have no trouble in falling to sleep. They are resistive to sedatives. No matter how much you give them they wake up early anyway. I am speaking of the intramural depressions.

A good many of the mild cases come to you complaining of a bitter taste in the mouth. Most of them say that they work but get no kick out of it; they get no satisfaction out of it; everything is the same.

I know that I am hurrying these things too much, but once you get into the idea of thinking about them you will recognize them. You will be able to treat them better.

Treatment of the emotional depression is to avoid useless surgery. We ought to prevent suicide. Specific treatment is very helpful. Symptomatic treatment is relatively of little use. Of course, you have to see these patients and help them along, but most of the time you don't accomplish anything.

In summary then, I should like to state that if you want to be an up-to-date internist, you have to know certain minimal conditions that I dub as neurological or neuro-psychiatric emergencies. You should think of neurology in terms of syndromes; not in terms of symptoms but in terms of disease. If you do that, you will undoubtedly pick up a great many conditions in cases in whom you can prevent invalidism or even death.

On the psychiatric side, the early recognition of depression and the ability to put it where it belongs is something that every good clinician should be able to do.

1832 Spruce Street.

DISCUSSION

DR. M. A. TARUMIANZ (Farnhurst): Mr. President, I can't help but admire Dr. Yaskin, who has had 30 years of teaching and fighting against certain elements, but he still has his courage and his ability to transmit to people that psychiatry is not a psychological problem or psychological science. It is part of medicine, an important branch of medicine. The psychological must go hand in hand with the organic, physical existence of human beings.

I think Dr. Yaskin has many times gone against certain individuals who have a tendency to create among certain physicians the feeling that psychiatrists are an extraordinary group of individuals who have no medical interest or medical knowledge or experience. I think he has given you the importance of neurological emergencies which we see every day, and he has given you the facts pertaining to the importance of depression, manic-depressive psychosis, reactive depression, in many psychoneurotics, involution melancholia cases.

I think depression is one of the most important illnesses in medicine. It isn't called a symptom. Depression is not a symptom, but depression is a disease entity. Thus, he has elaborated on how to recognize the depression and how to treat depression in early stages. Today it is very easy to treat most of the cases of depression. They respond well, and I would say that we have a better prognosis in depression if treated adequately than in any other type of psychiatric problems. Certainly, particularly in the cases of involutional melancholia, they respond to shock treatment, followed by psychotherapy. Very few cases do not respond to treatment. Then a frontal lobotomy is considered.

DR. GEORGE J. BOINES (Wilmington): Dr. Yaskin gave us a very complete outline of the neurological emergencies, but I was quite surprised that he didn't mention bulbar poliomyelitis.

In 1934 bulbar polio was hardly recognized. However, I think we know today that bulbar poliomyelitis is an emergency, and the early diagnosis, the early hospitalization and the proper treatment is the thing to do. Diagnosis

is not hard to make if one keeps in mind that there are 12 cranial nerves and the parts which they supply from the neck up.

DR. YASKIN: I am grateful to Dr. Boines for mentioning bulbar polio. I didn't say a word about the aneurysms, which is one of our great acquisitions in the last two decades. Subarachnoid hemorrhages were a lost cause until we began to localize them by arteriograms, and ligate them.

Polio is another example. There are many more advances that have been made. I think if I could stimulate in you the desire to look upon neurology as something living, not something that the other fellow does to amuse himself but something that you can use in your everyday practice, if you do that and integrate it as part of your internal medicine or general medicine, or general surgery, you will find it extremely interesting, if not anything else, possibly something else too.

PITUITARY CRETINISM

CHARLES WILLIAM DUNN, M. D.*
Philadelphia, Pa.

In 1944, under the title of Pituitary Myxedema[1] we reported the case histories of five children who had been diagnosed as cretins during infancy and thereafter were treated with thyroid extract. There were 2 male and 3 female children, varying in age from 3½ years to 14 years of age. All of these cretins had been referred to the author because they developed thyrotoxic reactions when thyroid extract was continuously administered at a dosage level which is readily tolerated by the average cretin child of a similar age. Their clinical history throughout the years revealed a consistent intolerance to thyroid extract and a recurrent necessity for interrupted thyroid therapy in order to control the clinical signs of their hypothyrodism or cretinism.

Another notable feature in their clinical history was that in spite of interrupted thyroid therapy they had maintained a degree of mental development which was inconsistent with the very low total amount of thyroid therapy administered and a diagnosis of cretinism.

Their earlier prethyroid treatment pictures showed definite cretinic facial features and enlarged tongue. The early clinical history and the retardation of physical development and mental responses was consistent with cretinism.

In their post-infancy period they began to show aberrations from the usual pattern of the thyroid treated cretin. Mentally, developmentally and in adaptability to their environment and in their ability to be trained; their accomplishments were superior to those of a thyroid treated cretin having a primary thyroid deficiency.

The general clinical picture presented by these five children was more a combination of pituitary infantalism, pan-hypopituitarism type; and a post-thyroidectomy myxedema or the thiouracil induced type of myxedema and not that of thyroid cretinism. Thyroid therapy when initially administered had promptly effected, in fact almost erased; the facial features of the cretinism and after thyroid therapy the child had normal facial features and expression.

In fact these differentiations between the true thyroid cretin and the group of children diagnosed as pituitary cretinism was so much in evidence that the mother of the first case observed a 14 year old female child; had noted these observations. Because she had made these observations in her own child, she investigated the clinical history of numerous other cretin children and discussed the clinical history with the parents of these cretin children and failed to find these differences in other cretins. Thus, the mother withheld all information concerning the original diagnosis of cretinism in her child at age 1½ years and merely stated that the patient had required and received thyroid therapy chiefly to resolve the chronic stages of an infection; that she did not tolerate prolonged thyroid therapy nor had it aided her physical or genital development. During the past few years on the advice of her physician she had received practically no thyroid therapy. During this three year period no progress in statural growth or genital development occurred.

On the basis of the type of retarded growth and genital development at age 14 years, the signs of secondary hypothyroidism commonly seen in panhypopituitarism, but present here to a greater degree than usually observed; a provisional diagnosis of pituitary infantalism

*Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania; Consulting Endocrinologist, Delaware State Hospital, Delaware Hospital.

and chronic pituitary myxedema probably due to a pituitary cyst was made. A complete x-ray study of the skull, sella turcica and osseous system was ordered, also blood cholesterol and blood studies. Only until this provisional diagnosis was made and reinvestigation ordered did the mother reveal that cretinism had been diagnosed and frequently confirmed since age 1½ years.

The x-rays revealed that an enlarged, adult sized sella turcica was present and the general osseous pattern corresponded to that observed in a primary anterior pituitary lesion more than that observed in a primary thyroid lesion present during childhood. The B. M. R. was minus 16 and the blood cholesterol was 220 mg. per 100 cc of blood.

We also noted that this patient did not present what we designate as the retarded signs of foetal development which are consistently observed in thyroid cretinism. We consider these characteristic cretinic features to be: a persistent and measurable degree of mental defect at all ages, the harsh and characteristic cretinic voice tone, the deficient osseous formation and dental developmental growth pattern of cretinism, the tegumental abnormalities and the lustreless and coarse hair; the excessive persistence of lanugous hair; the hypotonia and deficient musculature; the umbilical hernia and potbelly and the absence of palpable thyroid tissue or degenerative thyroid pathology.

The clinical features and x-ray findings of pituitary cretinism as described herein have been observed and confirmed in two more cases, both females, one at age 10½ years and the other in a female age 58 years. Both individuals had been diagnosed as cretins during infancy, and both patients have experienced the same intolerance to and thyrotoxic reaction from continued thyroid therapy and lack of developmental response when treated with thyroid extract.

This report concerns only the 10½ year old female child with a hospital record and diagnosis of cretinism dating back to age 5 years. Our purpose is to give further evidence of the clinical entity of pituitary cretinism and to substantiate the therapeutic results stated in our original report of 1944.

The sixth case of pituitary cretinism was first examined at age 10½ years at the Endocrine Clinic of the Delaware Hospital, Wilmington. A diagnosis of cretinism had been made at age 1½ years. The chief complaints at age 5½ years were: retarded physical and growth development, mental and physical sluggishness, thin scalp hair and scaling of the skin in general. The child played alone for hours, was non-irritable and "drags along." Enuresis and constipation persist. Weight 34 pounds and height 37 inches.

A diagnosis of cretinism was made and thyroid extract 1½ grains daily in divided doses was prescribed. Within 3 weeks thyrotoxic symptoms were observed. Thyroid was reduced to 1 grain daily. After a short period of time intolerance for this dosage and thyrotoxic symptoms again developed. Eventually because of extreme nervousness, overactivity and weight loss, thyroid therapy would have to be discontinued until the sluggishness and puffiness of the face reappeared. Therapy would be resumed and continued until physical appearance improved and sluggishness disappeared.

At age 8 years marked lordosis and slight scoliosis developed. X-ray studies at this time showed a bone age of 4 years. Again the diagnosis of cretinism was confirmed.

On October 25, 1946, the patient was referred to the Endocrine Clinic, and examined by the author.

Summary of Clinical History. The preceding clinical history was confirmed. Diagnosis of cretinism at age 1½ years, retardation of physical and mental growth, recurrent enuresis, gastro-intestinal disturbance, mental and physical sluggishness, delayed eruption of teeth and general hypotonia since infancy. Delay in walking until age 3 years and difficult speech until age 6 years. Persistence of mental sluggishness, retardation of general physical development and retarded growth.

The child had entered school but her progress was poor and she required special class training. She was unable to maintain scholastic advancement in her age group.

At age 5½ years; 1½ grains of thyroid produced toxic reaction within three weeks. Since age 1½ years the patient had received thyroid extract for her "gland trouble" but had shown little improvement from the treatment.

Response to thyroid therapy up to age 10½ years: The patient responded favorably to thyroid extract, orally administered, grain ½ twice a day, however, continuation of this dosage produced thyrotoxic reactions and thyroid therapy would have to be interrupted. Discontinuing thyroid therapy brought about physical and mental sluggishness, anorexia, constipation and a more sluggish state of development.

Physical Examination. The responses, attitude and general appearance of the child were distinctly immature.

Height: 45¼". Lower measurements: 21". Span: 45½". The physical examination revealed a female child, age 10½ years, with retarded growth and general physical development. She was shy, the facial appearance was immature but non-cretinic, the scalp hair was dark and lustreless. The skin had a chloratic tinge and was dry. The subcutaneous tissue was increased. The eyes were bright and the eyelids were non-puffy. The teeth were small, the incisors were boxy in shape with increased spacing. The tongue was not enlarged. The thyroid was palpable but very small. The subcutaneous tissue of the chest wall was increased. The heart rate was a slow normal, no murmurs. The lungs were normal.

Abdomen: pot belly; no umbilical hernia present.

Extremities: diminished lower measurement. The musculature was moderately developed.

Primary and secondary sex characteristics: external labia underdeveloped for age 10½ years, no pubic hair. Breast development: areola and nipple developed. No breast tissue felt in fatty deposit.

The pattern of developmental retardation which was apparent at age 1½ and had persisted to date; the scholastic record though deficient was above that of a cretin; the sensitivity to thyroid therapy, and its lack of stimulative action on statural development and the adequate effects on mental sluggishness along with the absence of "signs of retarded foetal development" such as are evident in thyroid cretinism and a small thyroid gland indicated a primary anterior pituitary pathology and a secondary thyroid deficiency state which we have designated as pituitary cretinism or myxedema.

X-ray report October 25, 1946, age 10½ years. X-rays skull, hips, knees, wrists. Examination of the skull shows the walls of the calvarium normal. The sella turcica measures 10 mm. in depth and 13 mm. in length. This is larger than is normally found in a child of this age and may be significant. Both hips and pelvis, right and left knees appear normal. The bones of both hands show no evidence of pathological change although there is some retardation in the maturation of the bones of the hands and wrists. The bones of both wrists appear to be of a bone age of about six years and nine months, with a retardation of bone growth by about three years and nine months.

December 27, 1946, blood cholesterol 362.

The retarded growth and genital developmental pattern of the pituitary infantalism, the grade and type of secondary hypothyroidism described in the text and the enlarged sella turcica indicated the primary endocrine pathology was pituitary in origin and the diagnosis was pituitary cretinism.

Endocrine therapy was instituted in January of 1947 as follows: "Armour" anterior pituitary extract, gr. 1; thyroxin 0.15 mg.; calcium glycerophosphate, gr. 3; twice a day.

On this therapy she became alert and active. In two months the dosage was reduced to one capsule daily because of nervousness. After 6 months of therapy her weight was 58 pounds and her height was 47¾". After one year of the above therapy one capsule and two capsules a day on alternate months, she weighed 67½ pounds and was 49" tall. A total gain in height of 3¾" for 1 year.

She had worn a size 6 dress for at least 3 years and now required a size 9 dress. Her breasts were beginning to develop. She was more alert, active and had wider interests. Her facial expression was more mature and she was less shy and more assured in herself. Her scholastic work had markedly improved.

After 1½ years of therapy her weight was 63 pounds and she was 49¾" tall. She was advanced in school and was manifesting a more general outside and home interest.

After 2 years of therapy weight was 68 pounds and height 50½". Breast development advanced. The dosage of thyroxin was

reduced to 0.1 mg. twice a day because of the improved clinical state and the now normal age osseous development. X-ray study at age 12½ years showed osseous age of 12-13 years.

The total gain in height and weight was as follows:

	height gain	weight
After 2 years of therapy	5-¼"	68 pounds
After 3 years of therapy	8"	81 pounds
After 4 years of therapy	10-¼"	94 pounds
After 4-½ years of therapy	10-¾"	95 pounds

The menarche occurred 3 years and 11 months after instituting therapy and during this period the breasts developed to normal. After the onset of the menarche, anterior pituitary was discontinued but was resumed 2 months later because the patient's mother stated she was not doing so well with only thyroxin 0.2 mg. daily. Two months later the second menses appeared on April 9, 1951. The physical and mental energy improved.

April 20, 1951—X-rays: skull, hips, wrists. Examination of the skull shows a slight increase in the size of the sella turcica. The area being approximately 125 mm. as compared with a top normal of approximately 85 square mm. for a child of this age. There is a slight retardation in the development of the bones of the wrist.

April 20, 1951—R. B. C. 3,000,000 Hb. 68% —10.6 gms. Blood cholesterol 208 mg.

The clinical response to the continued oral administration of anterior pituitary, thyroxin and calcium glycerophosphate in this case of pituitary cretinism was a stimulation of growth and genital development. The therapeutic results previously reported in five cases of pituitary cretinism were substantiated in this case.

A total gain of 10¼ inches in height resulted from 4 years of anterior pituitary-thyroxin-calcium oral therapy in a child who had exhibited practically cessation of growth for a period of three years. Genital growth development, equally retarded, had been advanced to normal, with the appearance of the menarche on or about the normal time. This result equals that obtained in Case I of the original report. The scholastic history of the patient is of interest. Following are excerpts from her school report:

"Since 1941 at age 6 years, C. M. had spent three years of unsuccessful work in school. She simply could not conform to the routine of a regular classroom.

In September 1944, she rated 76 on the Stanford-Binet test. She was placed in an opportunity class where she remained three years. During this time through many experiences she developed an understanding of formal reading and its meaning. Her muscular control showed a very encouraging development in handwriting. She learned to write numbers to 100.

In September 1947, (after ½ year therapy) she was placed in a regular second grade class where she adjusted well to the routine of regular class work. She was more dependable than the average second grader. She read seven books on first and second grade level. She developed good handwriting. Interest in music began.

She made average progress the following year in the third grade. She read seven readers on second and third grade level. She was good in spelling and written work. She improved in arithmetic and learned to apply simple multiplication and division facts in problem work. In November 1948, she rated 64 on the Kuhlmann-Anderson Group test.

In 1950 (after 3 years of therapy) her work shows steady progress in the fourth grade. Reads with fair ease and understanding from the easier fourth grade material. Has very little trouble with studied or applied spelling. Good handwriting with good muscular control. Knows the harder number combinations and can apply them fairly well in fourth grade problems.

According to the Iowa Basic Skills Achievement tests her scores were:

	September 1949	May 1950
Reading comprehension	2.4	3.6
Reading vocabulary	2.1	3.4
Arithmetic fundamentals	3.9	4.2
Arithmetic reasoning	3.0	3.8
Language	3.4	3.9

Reported by teacher."

Following are excerpts from examinations at Mental Hygiene Clinic, Delaware State Hospital:

"C. M. was first tested at the Mental Hygiene Clinic when she was three years and six months old, which was about eight years ago. At that time she was considered mentally definitely retarded, but probably not deficient; as at least of borderline intelligence. She is an 11 year old girl but looks more like a seven

year old in body size. She is friendly, expressive and cooperative child. She responds readily. She rates low average in mastery of the mechanics of language; and her vocabulary is inferior. In the fundamental school subjects, she is seriously retarded for her age level. She has low average intelligence. In reading, spelling, and arithmetic, she is seriously retarded for her age."

Following are exerpts from examination in Mental Hygiene Clinic, Delaware State Hospital, March 6, 1950:

"C. M. is an attractively featured girl of small stature. She is cooperative and attentive. Her ability to distinguish between degrees of accuracy of her actions is impaired. She is alert and sociable. She is consistently retarded in all mental functions. Her general level is not, however, defective. She is of low average intelligence. She has done as well as can be expected from her capacity."

Conclusion. The differential diagnosis of pituitary cretinism from thyroid cretinism is now required because of:

1) The greater degree of physical, sexual, mental, social and economic development obtainable in pituitary cretinism from adequate anterior pituitary and thyroid therapy as compared with thyroid therapy alone in pituitary cretinism and thyroid cretinism.

2) X-ray investigation of the size of the sella turcica should be made in all cretins. The enlarged sella turcica combined with the clinical features of pituitary infantalism and myxedema and a mental development above the level of the average cretin indicates the presence of pituitary cretinism. The signs of retarded foetal development usually present in thyroid cretinism are not found in pituitary cretinism.

3) In pituitary cretinism the cretinic facies and other constitutional and functional signs of severe hypothyroidism is the result of an anterior pituitary thyrotropic deficiency.

4) The continuous and required dosage of thyroid extract which is well tolerated by the thyroid cretin produces thyrotoxic reactions in pituitary cretinism. This reaction appears to be characteristic of the pituitary cretin since it has been observed in all seven cases observed by the author. Lerman and Stebbins[2] have reported that the administration of thyroid extract to cases of adult pituitary myxedema precipitates fatal attack of unsuspected adrenal cortical failure.

5) The primary endocrine pathology in pituitary cretinism is in the anterior lobe of the pituitary gland. The thyroid gland is non-pathological. Its secreting cells are small but functionally dormant. They are not being stimulated by the anterior thyrotropic factor. The primary pathology in thyroid cretinism is in the thyroid gland or the result of its absence. There is no deficiency of anterior pituitary thyrotropic factor in thyroid cretinism.

6) The anterior pituitary pathology is presumed to be a cystic lesion because of equal expansion of the diameters and the non-eroded appearance of the sella turcica.

Summary. A sixth case of pituitary cretinism and the therapeutic results of 4½ years administration of oral anterior pituitary, thyroxin and calcium glycerophosphate to a female child age 10½ years is reported. The importance of differentiating pituitary cretinism from thyroid cretinism has been discussed.

265 South 19th Street.

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EPILEPSY AND CONVULSIVE DISORDERS AS SEEN IN THE SEIZURE UNIT OF THE GOVERNOR BACON HEALTH CENTER

JOSEPH HUGHES, M. D., ROY READ, M. D.,
HAZEL MADRY, M. S. W. and
IRENE NOWLAND, R. N.
Farnhurst, Del.

Epilepsy results from brain damage. The convulsive seizure represents the mass firing of cortical neurones in response to a focus of irritability. Infections, trauma, degenerative lesions, biochemical abnormalities or congenital defects can set up trigger zones for the seizure. Heredity plays a decreasing role of importance and at present the hereditary role is conceded to be that of transmitting only a susceptibility for seizures.

Epilepsy involves three to five patients per thousand in the general population. On the other hand as many as fifty per thousand suf-

fer, at one time or another, a convulsive seizure in their lifetime.

The seizure control unit of the Governor Bacon Health Center has been functioning since March 1949. Since that date 620 patients have been examined for epilepsy. Each of these patients was screened electroencephalographically. 92 patients of this group were hospitalized for additional diagnostic procedures and treatment. The unit provides both diagnostic and treatment facilities for residents of Delaware who are subjected to convulsive disorders. Patients are referred to the Center by their own physician or by other hospitals, Public Health Agencies, the Courts and Rehabilitation Centers. Neurological, psychiatric, psychological and electroencephalographic examinations are made on each patient. The nursing care is directed towards rehabilitation and includes training each patient in the appreciation of his own needs in terms of suppressive therapy and other medication or corrective procedures. Social service appraisal of the home situation and the problems growing out of the patient's illness serves as the basis of bringing knowledge and understanding of epilepsy both to the family and to the patient so that healthy attitudes towards the patient's seizures may prevail on his discharge home. While at the Center patients of school age are carried on an educational and/or vocational training program so that their schooling will not suffer through hospitalization.

In the group of 620 patients studied to date grand mal seizures with generalized electroencephalographic abnormalities were seen in 540 patients. Petit mal seizures were seen in 37 patients. These showed typical three per second spike and wave patterns in the electroencephalogram; focal electroencephalographic abnormalities were also noted in 43 patients. All of these patients benefited from suppressive medication directed in sufficient dosage to control the seizures. Those patients whose seizures were alleviated always reflected this clinical improvement by a parallel improvement in the electroencephalogram. It necessarily follows that those least improved were those patients who had the most extensive brain damage. Most of this group of patients were likewise handicapped by severe mental deficiency on an organic basis. Suppressive therapy has included the use of phenobarbital, dilantin, thiantoin, tridione, paradione, phenurone and hibicon. The last mentioned drug being a new anticonvulsant. In general grand mal was best controlled with dilantin and phenobarbital; petit mal with tridione or paradione and phenobarbital and psychomotor states with dilantin or thiantoin or phenurone and phenobarbital. Phenurone should be used with care because of reactions. There were no notable toxic reactions from any of the anticonvulsants used in this series. The explanation for this lies in the close supervision which all patients receive while under treatment.

The Seizure Control Unit has as its policy the maintenance of very close relationship with the family, the referring physician and the social agencies of the community. The goal of therapy may be stated as the control of seizures and the return of patients to their respective families where treatment may be either continued by the referring physician or if desired as an out patient of the Governor Bacon Health Center.

PSYCHOTHERAPY CONFERENCES AT GOVERNOR BACON HEALTH CENTER

EARL A. LOOMIS, JR., M. D.*
Philadelphia, Pa.

The Governor Bacon Health Center stands in a unique relation to the state of Delaware and each community therein. It provides a setting for prophylactic and remedial management of organic and functional disturbances of intellectual performance, learning, speech, reading, writing, and emotional maturation. The disturbed or handicapped child can be exposed there to diagnostic and therapeutic procedures administered by a coordinated team of specialists in all branches of medicine and the sciences of human behavior applicable to the patient's disorder. Not the least of the functions of Governor Bacon Health Center is the provision for individual and group psychotherapy. It was with a view to learning, sharing, and enhancing the techniques of psychotherapy with children that the psychotherapy seminars were established. Now, at the beginning of their second year,

*Consultant, Governor Bacon Health Center.

their efforts and achievements can be summarized.

Established for the training of the full psychiatric team, the seminars were attended by members of the psychiatric, psychological, and social work staffs. In addition specialized teachers, occupational therapists, and chaplains attended. The training and orientation of the participants varied from those having their initial exposure to clinical psychotherapeutic techniques (as in the case of some of the psychology and social work interns) to fully qualified child psychiatrists, psychologists, and psychiatric social workers, some of whom were undertaking personal psychoanalysis. Meetings were held once weekly, and on the whole attendance was faithful and consistent.

The plan of the seminars usually included one session for group psychotherapy for the presentation of material from the literature and one session for supervision of a case carried in individual psychotherapy. The latter was along lines similar to the continuous case seminars of psychoanalytic institutes.

Group psychotherapy was undertaken by quite a number of individuals, including members of each of the disciplines mentioned above. Membership in the groups included children as young as seven to ten years of age and as old as fourteen to sixteen years of age. The groups consisted of six to ten children. The approach in each group varied, being adapted both to the needs and preferences of the children and to the training and temperament of the therapist. Most groups contained both neurotic and acting-out children. One group contained physically handicapped children. The therapists' approach varied from sports and crafts activities to a quite directly interpretive psychodynamic technique. Therapists were given a great deal of freedom in both the completion and the handling of their groups and were encouraged to adopt and devise techniques consistent with their own preference and capabilities.

During the individual psychotherapy continuous case seminars, one case was followed throughout the entire year. It was presented at first by a psychiatric social worker and later by a child psychiatrist when the case was transferred because of the departure of the earlier therapist. The work throughout the year was of a high caliber and reflected luminous insight and warm human understanding. It was stimulating to observe the maturation of the therapists and other participants as they shared ideas and sought together the solution of many dark mysteries.

The general discussions and presentations from the literature revolved around topics germane to the institution: the psychodynamics of delinquency, the neuroses of childhood, the institutional management of children who are ill in body and mind, the various techniques of psychotherapy, the handling of the feelings of the child for the therapist and the therapist's feelings for the child, the contagiousness of anxiety.

The function of the consultant was to moderate at the meetings, encourage discussion, and at times assist in dynamic formulation or therapeutic planning. His role was a pleasant one, due to the acumen and good will of the staff. Looking backward and then forward, I am convinced that Governor Bacon Health Center deserves to continue its growth and to extend further into the community a knowledge of its function and techniques in order that each of the citizens of Delaware may ultimately benefit, directly or indirectly, from the scientific and warmly sympathetic attitudes toward children and child rearing which are expressed in the work of the Center.

STUDY OF A SCHIZOPHRENIC FAMILY

F. A. FREYHAN, M. D.*
Farnhurst, Del.

The Delaware State Hospital offers a unique opportunity for psychiatric family studies. It is the only mental hospital in a small state, has, consequently, a substantial number of closely related persons among its patients. This clinical material, consisting not only of patients now at the hospital, but including those who had been patients in the past, or were seen at the Mental Hygiene Clinic for a variety of personality disorders which did not require hospitalization, constitutes an exceptionally rich source for investigations of psychologic, sociologic and cultural aspects of mental illness.

The following report acquaints us with a

*Clinical Director, Delaware State Hospital.

family whose life struggles are far from being ordinary. The family history, in as far as psychiatric aspects are concerned, begins in Poland, continues in the United States, but has a special chapter which reveals the chaotic conditions brought about by the political events of World War II.

We shall let this story unfold in the chronologic fashion in which the persons involved came to the attention of the Delaware State Hospital:

1. Stella M., 18 years old, entered the Delaware State Hospital on August 6, 1930. About a week prior to admission, Stella had become strangely self-absorbed, had refused food and talked of religious visions. Her inner experiences had excited her to the point of psychotic ecstasy, so that hospitalization became a necessity. The family investigation carried out by the Social Service Department at the time of Stella's admission reveals the following pertinent facts:

Stella's parents are Polish immigrants who came to the United States in 1913. Unfortunate circumstances forced the family to split: Two of the four daughters, including Stella, were brought to this country, whereas two were left behind with relatives where they remained. Life in this country fell short of expectations. The father, always a poor provider, worked only irregularly, drank to excess and served two terms in the Workhouse. He was described as an aloof person who showed little affection or interest for his family. He died in 1929 of heart disease. The mother depended on help from charity organizations as she could not contribute to the support of the family because of chronic disabling rheumatism. Her own mother and a maternal uncle had been mentally ill. Both had suffered from a chronic disease which she described as "similar" but about which she could give no further information. Her mother had always been cared for at home but her uncle spent his life in an institution somewhere in Poland where he died at an early age.

Stella had always been a quiet child who helped at home and seemed rather ambitious. Her physical development had been normal. She attended school until she was 15 years old, then went to work in a jute mill and later in a laundry. She apparently was well liked in the neighborhood and devoted much of her own time to church work. About a month before admission, she felt disturbed by the attention of a man whom she disliked but feared. She was afraid to get rid of him as she suspected that he would harm her if completely rejected. Soon after this episode, she became increasingly religious, spoke of entering a convent and spent entire days praying in church. She then refused food at home, explaining "There is dirt in it," and spoke with some elation of "seeing God." At the time of admission, she was in a state of religious ecstasy, saw a "brightly illuminated cross in the sky" and demanded "the Testament should be written in red blood." Within a few weeks, these experiences faded away, she became calm and developed some doubt regarding the reality of her visions. A few months later she seemed well enough to return to her home and job. For about three years she worked regularly and gave the impression of being quite well adjusted. Ever so often, however, she complained that men molested her. These stories appeared exaggerated, if not fabricated, to those who investigated them. In the fall of 1934 ideas of sexual assault became so dominant, her accusations so bizarre, that hospitalization became again necessary. Mental examination on readmission revealed her to be extensively delusional, withdrawn and obsessed with sexual fears ("I do not want to be anybody's naked woman.") She became progressively more passive, displayed extreme hostility and suspiciousness, frequently attacked people who disturbed her in her desired isolation.

The subsequent clinical course has been one of complete stagnation. Neither insulin coma therapy, electroshock treatments or occupational efforts have had any significant effects on her attitude. She presents today the picture of a deteriorated schizophrenic individual who is emotionally blunt, has no outward interests, shows manneristic behavior and becomes frequently assaultive. She has not left the hospital since 1934.

2. Kathryn M., 43 years old, was admitted to the Delaware State Hospital on October 16, 1950. Kathryn is one of the two sisters who was left in Poland. At the time of the departure of her parents she was 9 years old.

She was born November 15, 1905 and, in the estimation of the mother, seemed somewhat retarded in her mental development. The mother remembered her as "a sickly baby" who was slow to learn and did not go to school before the age of 8. Very little is known about her life after she was given over to relatives. Her family had lost contact with her after the Germans invaded Poland. We know today that during the war years she was compelled to work in labor camps. At the end of the war she became a displaced person and spent several years in a D. P. camp in Germany where she was finally located by her family. An immigration visa was secured which enabled her and her six year old illegitimate daughter to enter the United States in 1949.

In her mother's home she appeared neither happy nor capable of making any plans for her future. She expressed resentment and bitterness toward her family for having been left in Poland and been exposed to bitter experiences. The family noted that she drank considerably, neglected her appearance and became increasingly morose and irritable. Questions concerning the paternity of her child led to heated arguments and mutual accusations. After three months she left the mother's home, went to the police and accused her family of mistreating her. Social agencies came to her assistance and found her a housekeeping job with a friendly couple who spoke her language. At first, Kathryn seemed happy, contented and began to make plans for her future. A few months later, however, she complained of mistreatment and again became morose and hostile. Her employer, as well as his neighbors, stated that they were afraid of her because "she ranted, raved and threatened to use the butcher knife on various occasions." Representatives of a social agency investigated, found her mentally disturbed and had her committed to the Delaware State Hospital.

When first seen at the hospital she was agitated and depressed. She paced the floor, restlessly, trembling and mumbling over and over again that her girl had been killed by her family or that she herself had burned her child. Marked psychomotor restlessness persisted until she had been given several electroshock treatments. Hereafter she became calm but there was no apparent change in her ideation. Attempts to reassure her failed. Within a short time she again became upset, attacked nurses and attendants on frequent occasions and displayed hate toward everybody in her environment. Feeling trapped, she tried to get out by offering pennies to the attendant.

While it was assumed at first that she suffered from an affective disorder which would respond favorably to therapy, further developments altered the clinical picture. Paranoid behavior, persistent agitation and negativism (refusal to eat or participate in any ward activity) dominated in spite of repeated courses of electroshock therapy, hydrotherapy and various types of sedation. It became necessary to transfer her to a disturbed ward since she screamed and yelled, often for many hours, without letup, especially at night and often in spite of heavy sedation. Actually, Kathryn acquired the reputation of being one of the most persistently disturbed patients in the hospital. There has been no change in this pattern since admission. At the time of this writing, patient is being prepared for a transorbital lobotomy which constitutes the last therapeutic resort after everything else has failed.

3. Peter M., 35 years old, was admitted to the Delaware State Hospital on July 13, 1951. The city police complained that this patient repeatedly made a nuisance of himself by interfering with street traffic. He had developed the habit of standing on busy street corners, reading from his Bible and preaching to the public.

Peter was born in Wilmington, Delaware, in June, 1916. He completed the 8th grade in school, then took vocational training to become a machinist. Although he was eager and intelligent, he could not make a satisfactory vocational adjustment. He held many jobs but never kept them for any length of time. He served time in a CCC camp and three years in the Army where he apparently made a satisfactory adjustment. Following the war, he managed to support himself but did not have any steady jobs.

Although he mixed well with people, he gave the impression of being bashful, quiet and self-centered. His interests included reading,

sports, poolrooms and automobiles. Women did not seem to attract him.

In 1939 he came for the first time to the attention of the Mental Hygiene Clinic where he had been referred for mental examination from the Workhouse authorities. (He served a term for larceny.) The examining psychiatrist described him as a man of "strong convictions" regarding social and religious issues. He did not care to speak about his arrest, explaining: "I only want to look ahead. Anybody that thinks about his mistakes will go nuts." With regard to his family, he made it quite plain that he believed his sister, Stella, then a patient at the Delaware State Hospital, to be sane and entitled to her own religious beliefs. Concerning himself, he did not know of any personal problems and presented himself as a self-sufficient and independent person. The psychiatrist stated that he found this patient to be "pre-psychotic" and he recommended regular visits to the clinic for further study and therapy.

During the following years Peter was seen in court on numerous occasions. His record includes charges of assault and battery on his mother, later on his wife, and recently his niece (the 7 year old girl of Kathryn). Also recently, there was a charge of breach of peace for "directing traffic at a street corner and mouthing some religious jumbo." He married in August, 1950 but separated in December. His wife was married previously and had a child by him before she obtained the divorce. His wife found him to be quite peculiar. He refused to shave or have his hair cut because "it would please the Jewish." He was obsessed with anti-Semitic thoughts. Several times he told her that he felt "possessed by Jesus" whom he tried to get out of his brain by falling to the floor, screaming that his soul was agonized.

When admitted he presented a somewhat peculiar appearance because of his fully-grown beard and the long, curly hair. He spoke with some reluctance and discussed his situation with an artificial air of superiority. Since he had recently been arrested for having beaten his niece with a leather strap, he assumed that this was the reason for his commitment. When questioned about this incident, he defended his action quite determinedly, stating "I will beat her again until she has a bloody behind." It seems that he suspected her of showing some sexual interests and, therefore, felt that a severe punishment was indicated. Concerning his religious ideas he did not offer any spontaneous comments. He went to the ward with the dignity of an unrecognized prophet. Once on the ward his attitude became openly hostile. He threatened to kill anyone who would subject him to examinations or treatments. There was no doubt in his mind that all doctors were Jews, criminals without a conscience who would kill patients at will. In spite of his immense hostility towards the doctors he nevertheless resumed his conversations as he seemed anxious to proclaim his ideas. While he remained most reluctant to talk about religious matters, some of his remarks suggested the presence of auditory hallucinations (conversations with God). Religious matters constituted "personal problems" which he did not care to discuss. He preferred speaking about exposing the physicians and sacrificing himself for the sake of the other patients at the hospital.

A few days later he felt sure that he would not be killed and talked in a more amiable fashion. For the sake of brevity, some informative quotations shall follow: "We are a very stubborn family and have a will of our own. I hate any form of compulsion, prefer loafing to taking orders, that is why I did not like it in school. I wanted my freedom. I hit my sister with a strap, hit her on the head until she became silent. That is where she should have sense and that is where I would hit her again. I am not a lady's man, never was. I did not love my wife when I married her. She asked me to get married. When we went to the priest I actually cried but she laughed because I cried." Questioned about his hair and beard: "A few years ago I looked at my picture and felt ashamed, something looked wrong, seemed missing." Asked whether he likened himself to Samson, he replied smilingly "Could be. I look more like a man this way."

COMMENT

A psychiatric evaluation of these siblings must be sufficiently broad to include familial and individual aspects. Family studies of this kind have the methodologic advantage of

widening the clinical perspectives to a point where we can differentiate personality features which are unique from those which have generic roots. We find in the history of this family an impressive aggregate of genetic, psychodynamic and social data which emerge here in the light of both: their significance and their limitations. An assessment of genetic-characterologic factors provides some important information. On the mother's side there is mental illness in two generations, probably schizophrenic in nature, in view of the description of "similarity" of the disease. The father's personality shows certain traits, most frequently seen in the so-called schizoid or psychopathic person: aloofness, lack of drive and affection. We thus find a positive background for the specific predisposition as postulated by Kallmann and others. While it is no longer believed that a psychosis per se can be inherited, there is cumulative evidence of an existing genetic capacity (predisposition) for reacting to certain life situations with a schizophrenic type of psychosis.

M. Bleuler (Zurich, Switzerland) who investigates the clinical material of 700 schizophrenic patients and their 15,000 relatives, emphasizes the diversity of characterologic dispositions encountered in these families. He finds prevalence of certain traits and vulnerabilities regarding selective life situations which seem to be related to the schizophrenic psychoses in a given family group. Our family may conceivably fit into such a concept. We find a prominent representation of such traits as stubbornness, suspiciousness and self-centeredness, and there appears to be a singular lack of ability to adjust harmoniously to sex and religion.

Onset, course and type of psychosis present interesting differences. In the case of Stella, one recognizes the rather classical form of schizophrenia which shows the postulated characteristics of a "process-psychosis." Her personality deviates very early in life into autistic isolation which precludes further maturation. Her withdrawal appears final and therapeutic approaches cannot alter her condition. Kathryn, about whose personality we know very little, is already past 40 at the time of onset. Though affective elements seem dominant at first, we find a firm resistance to therapy and emergence of fixed delusions, followed by withdrawal into paranoid isolation. Peter, the most intelligent of the three, develops early into a determined individualist and comes closest to the schizoid personality type. In his case we are confronted with the dilemma of delineating personality and psychosis. Here is no "break," no definable onset of a process. Peter has not lost contact with society though relations have to be on his terms. He can be fanatic, cold and cruel when his convictions drive him, or be submissive, tearful and suffering when in painful conflict. His delusions and peculiarities are deeply ingrained parts of his total personality and he, therefore, offers poor prospects for therapeutic endeavors.

Had we only one or the other sibling to deal with there would be a great deal of temptation to construct psychodynamic connections between the individual life situation and the psychosis. However, no satisfactory answer can be found in the elaboration of psychoreactive elements without the assumption of a specific predisposition as we look at the family as a whole. While it would seem relatively plausible to "explain" Kathryn's breakdown in terms of a series of traumatic experiences, beginning with parental rejection, those would hardly suffice to account for the peculiar malignancy of her psychosis.

This report cannot provide solutions to unsolved problems but it may stimulate interest in the research — potentialities of psychiatric family studies.

SURGICAL INTERVENTION IN COMBINED PHYSICAL STERILITY AND PSYCHIC IMPOTENCE

A Case Report

HARRY S. HOWARD, M. D.*
Farnhurst, Del.

Freud once referred to pedaphilia as the perversion of "weak and impotent persons." This concept, of course, refers to the psychologically weak or impotent characters and the terms "castrated," "feminine," "immature," etc., used in discussing them refer to this psychologic impotence.

While the layman has certain concepts of

*Clinical Director, Mental Hygiene Clinic, Delaware State Hospital.

the physical development which he relates, (rightly or wrongly) to the sexual deviate, the medical profession does not accept this relatedness, so that physical factors are sometimes overlooked. Almost any experienced psychiatrist or physician can recall cases in which the voyeur or exhibitionist will recall derogatory remarks about his physical growth, his walk or his genital development.

However, it cannot be said that the patient does not see these physical inadequacies and does not suffer as a result of them. The patient is, after all, a layman.

The case of H. D. reveals a fortunate result from a recognition of this factor. H. D. is a white 29 year old male, seen at the Mental Hygiene Clinic at the request of a court after having been arrested on a charge of "lasciviously toying with a (6 year old) female minor."

Physical and neurologic examination revealed him to be of asthenic habitus, with a slight facial tic. He blushed easily, spoke in a barely audible voice but otherwise revealed no physical pathology. Careful questioning brought out the fact that he had had a Neisserian infection prior to marriage, that he had been married several years, and that about a year prior to the time the patient was seen his wife's failure to conceive had been traced to his failure to produce "an adequate sperm count."

That there were many psychologic trauma which contributed significantly to his "feminine" personality development cannot be doubted. His mother had been psychotic through much of his early childhood and adolescence (he wondered whether this could be inherited and whether he ought to go out with girls). His father, trying to fill the roles of both mother and father, failed to provide adequately in either role and certainly did not provide a very satisfactory object with whom he could identify. The patient himself had been enuretic until almost ten years old.

His wife, constantly desirous of children, pointed a scornful finger at his lack of "masculinity" and rejected his advances to her. Because of his conflict his sexual demands on her were at times excessive, childlike and unsatisfactory. In short, all of his previous conflicts and inadequacies were represented by his physical inability to give his wife a child. The desperation of his situation is well seen in his confession to the therapist that he had frequently thought of divorcing his wife, or of "letting her run" (with other men).

At the time of his arrest he had just undergone a vasotomy with presumably a reconstructive procedure in the vas deferens and in his initial interview made the following statement:

"Since my operation I've had no desire for kids. Everything has changed. Before that my wife was cold to me, nagging me about kids, resisting my sexual advances. Maybe that's why I turned — to children, etc."

Shortly after this his wife conceived. The patient characterized this as "a return of his masculinity." He was no longer subject to the jibes of his fellow workers. "He didn't have to prove his masculinity." Also he was able to criticize his wife's appearance and skill as a housewife — something which he had never allowed himself to do before. Also he found himself less anxious in his sexual approach to his wife and found more satisfaction in his sex life.

There can be little doubt that this young man had psychologic insults with damaging effects prior to the onset of the physical sterility. Nor can there be much doubt that this discovery of the sterility and his wife's subsequent reaction added much to his loss of self esteem. The important factor here is that the treatment of the physical factor facilitated his acceptance and understanding of the psychologic disturbances, something which would otherwise have been an extremely difficult task and this procedure reduced the psychotherapeutic procedure, immeasurably.

AUTO-FELLATIO
A Case Report

JEROME KAY, M. D.,*
Delaware City, Del.

Auto-fellatio may be defined as the practice of putting the male genital organ into one's own mouth. Because of the intrinsic physical difficulty as well as the psychic barriers, this is a rare practice and case reports

*Clinical Director and Acting Medical Director, Governor Bacon Health Center.

in the medical literature are few. Bragman described a man who, while sitting on the edge of a chair, lowered his head between his thighs, and upon experiencing an erection in this attitude, placed his penis in his mouth until an ejaculation occurred.[1] Kahn and Lion described a cool, egocentric, introverted, and self-sufficient man who practiced self-irrumination (self-fellatio) both to relieve sexual tension already aroused, on one hand, and to stimulate sexual excitement in himself, on the other.[2] Besides the overt reason, the act for this man serves to enhance his feeling of self-sufficiency, to give him a feeling of uniqueness and delight when exhibiting himself, and to rebel against his family and their moral standards.

Whereas this latter person was overtly homosexual, a more recent case had strong latent homosexual tendencies.[3] He was narcissistic, sexually self-sufficient through masturbation and auto-fellatio, and suffered paranoid and panic symptoms for which he was discharged from the military service.

We wish to report another case of auto-fellatio. The patient has been in psychotherapy for about 18 months and we do not want to report the details of the therapeutic process. Rather, we prefer to present a synopsis of this man's symptoms and background with comment about the significance of this unusual sexual perversion.

C. B. is a single, 22 year old man of Dutch background. He was referred for psychotherapy by a Veteran's Administration counsellor when he consulted the counsellor about his progress in a business college. His perplexity, anxiety, and inappropriate laughter led the counsellor to refer him to this physician.

The patient was a tall, asthenic man of 21 when first seen. Except for acne vulgaris, myopia and varicose veins of both lower extremities, physical and neurological examinations were essentially negative. His past medical history was non-contributory.

C. B.'s parents were both schoolteachers who had settled in a rural background and had become farmers. The patient describes his father as inconsiderate, unloving, and cruel. Little is known of his father's family. C. B.'s mother was described by him as "just crazy — she talks all the time, and she is stupid — no one listens to her or pays any attention to what she says." Of significance in the patient's maternal line, are the three maternal siblings, two of whom have been hospitalized in mental hospitals and the third an eccentric person. The patient was the youngest of 7 siblings. An older brother died at the age of 5 in the year of the patient's conception. This brother had the same given name as that of the patient, and the patient felt many times that he was wanted in order to replace his brother and for no other reason. He said "I have felt many times that I wouldn't be alive if the first Charlie didn't die." Promiscuity, erratic temper, irresponsibility, incestuous relationships between siblings — were all described as part of the family pattern by the patient. It is interesting that despite the 18 months of psychotherapeutic relationship, the patient did not mention this to his parents and expressed the desire for this physician not to contact any members of his family. We have, thus, only the patient's own impression and feelings about his family and he depicted an atmosphere of envy, cruelty, dysharmony, incest, and above all, complete rejection of himself by them.

When first seen, C. B. appeared anxious and extremely ill at ease. His attire was casual but extremely neat. There was marked variation in the volume of his voice and in the flow of words. He squirmed in his seat, avoided this physician's eyes, and revealed scatter of ideation. There were marked shifts in emotional tone and in the moods, themselves. He went rapidly from laughter to tears and a great deal of his ideation was accompanied by inappropriate laughter. About this latter, he commented "It's my way of expressing feeling — it's more social than crying." He expressed paranoid trends manifested by ideas of reference and feelings that people were prejudiced against him. Suicidal ideation was present with great loss of self-love. He commented "In fact, I don't like myself." He was guarded when attempts were made to elicit auditory hallucinations but it was apparent that they must have existed because he vaguely alluded to "voices which call me things." However, attempts to specifically

elicit them were handled in a most guarded manner. He believed in mental telepathy, feeling that his own thinking could telepathically influence other people's minds and vice versa. He complained of decreased efficiency in school with the inability to concentrate and attain that degree of efficiency which was compatible with his intellectual capacity. It was apparent that C. B. ws suffering from a schizophrenic reaction.

There is much in this man's early life to indicate that he was disturbed when young. As a young child, he was a nail biter, enuretic, slept with the light on because of a fear of the dark, and he commented that he used to chew his coat collar until he was 10 years of age. He used to pick his nose excessively and in fact, still does. His early school reports indicated excessive absenteeism, many latenesses, great variability in marks, and disobedience and restlessness. He remembers resisting the process of growing up and commented that when he was 5 he wanted to be even younger in order to avoid "the imposition of growing up." He remembers deep feelings of inferiority when he compared himself to his father when he was 10 and marked fears of death both of himself and of his father when he was 12. Throughout his life he was markedly conscious of certain physical inadequacies. He felt that his penis was too small. He was extremely ashamed of his acne and felt that his breasts were overdeveloped for a man and made efforts to bind them with elastic or squeeze them in an attempt to make them smaller.

For the first 7 years in school he did rather well although his marks were somewhat erratic. His marks definitely took a downward trend when he was in the 8th grade at the age of 14 and during this time rebelled against his schoolteachers. He graduated high school at the age of 17 with a C minus average ranking 69th in a class of 89. He left home after many quarrels with his family and became an occupational nomad. He then served 3 months in the armed forces, was AWOL 3 times and was ultimately discharged for failure to adjust ("Section 9"). He then spent a year wandering about the country making his living as a professional gambler using a "fixed deck," the details of which he had learned from books. He then took several more positions all of which he left after an enthusiastic start, and then entered a business college which he attended for 6 months before he was seen by this physician. He had a consistent pattern of beginning many new projects with boundless enthusiasm only to abandon them in a brief period of time because of disappointment that he had not mastered this new field.

It was the same way in his interpersonal relationships. His ties to his family were markedly ambivalent and loose. He had left home several years before he consulted this physician and had little contact with his relatives since then. He was self-conscious and guilty in the presence of women, young and old. With older men he was hostile and used them to borrow money without ever repaying them. With men of his own age, he became friendly quickly only to become hostile and discard them in a matter of a few weeks' acquaintance. When he lived at home with his family, he felt "like an outsider," and returned home when they were asleep so as to avoid them. When they gathered socially, he would go off by himself. He commented that he never had close friends and always felt alone. Once with his eyes tearful and with a most depressed mien, he said "I never go with any one — never, never, never. Oh, maybe I see them 3 or 4 times and then I can't stand to be with them any more. I can't stand to be with someone too long. I get the desire to run and get somewhere in a hurry." He mentioned how it was impossible for him to have feelings for other people and said "Really, the only person I feel for is for Charlie," (himself).

In the course of time certain symptoms, other than those already described as present at the time of the first visit and in the patient's background, came to life. His personal habits were extremely irregular, and his judgment poor. Once he commented "I let my feelings out all the time — anytime I feel like doing things, I do it." He was burdened with subjective feelings of guilt constantly and said on one occasion "When I walk down the street, anyone can have a dirtier shirt on than me, but if I have on just one speck, I feel bad." He was uncomfortable when in the presence of people talking or joking about sexual mat-

ters and could not tolerate the vernacular terminology for excretion and sexual activity. At the same time he could not say the word "love" and had a compulsive urge after studying the dictionary, to get up out of bed at night and check on the definition of certain words which flashed through his mind. He also suffered from a compulsive need to observe the genital areas of men. He had a fear that he was an aggressive homosexual and at times reached a point of panic when overly concerned about this. He lost a position in a factory claiming that he was fired because everyone knew he was a homosexual on the basis of his mannerisms of smoking and his high pitched voice. On one occasion, while driving down the street in the company car, he thought that individuals in an automobile which he was passing said "I hear you suck it" and he went over and complained to the police about this. This was probably a hallucinatory phenomenon occurring at the time he was suffering from a mild form of a homosexual panic.

The patient states that he began the practice of auto-fellatio (which he referred to as "auto-homosexuality") at the age of 14. He stated he committed the act about 6 times and began it because "I wanted to do something bad." It is interesting that after he first mentioned this act to this physician, he left the office and told us later he expectorated every 10 feet while walking home "in a daze." He began his description of auto-fellatio commenting that when he attained orgasm while masturbating, he facilitated the practice by putting tension on his leg muscles with his legs in extension. He then said that he flexed his thighs against his abdomen while masturbating and put tension on his leg muscles in that position. He then went on to mention "a lad" in his classroom at school who could put one foot behind his head. The patient then practiced placing one foot behind his head and then found it possible to do this with both feet. He then commented that he often wondered about acrobats in circus who can "go into all kinds of positions." He was aware of a "hole" (meaning a hollow) in his stomach which he noted when he had placed both feet behind his neck. This was obviously the diastasis recti. (The patient had much concern about castration fears and about the presence of a vagina in the male. He had many dreams in which both the male and female sexual organs appeared in the same person.) He was unable to perform auto-fellatio the first time he attempted it when in this position. However, later on he was able to perform this act on 6 occasions. He stated he did this in order to initiate sexual excitement and was able to complete the act in this manner. He states he expectorated the semen which resulted from the ejaculation. In the process of discussing this with this physician the patient was markedly tense, upset and said he had feelings of revulsion. Shortly after the consultation in which this material was revealed the patient attempted once more to perform the act but states that he could not do it for either physical or psychological reasons. During subsequent interviews he commented that he fantasied either having relations with a woman "in the ordinary way" or performing cunnilingus.

There are many interesting facets in the psychosexual development of C. B. We will mention just a few. He had slept in bed with his mother for several years of his earlier life. He remembers, at the age of 3, following an injury to his groin that he was too self-conscious to disrobe in the presence of his mother and sister. When he was 7, he states that he was seduced by his 11 year old sister. He feels that he was unsuccessful in this act and that he has constantly felt unsuccessful in life thereafter. He was markedly guilty about this experience and interestingly enough, utilized his urethra as his sister utilized her vagina later by introducing water into it as his sister had done before the sexual act which they performed. He frequently introduced foreign objects into his own urethra. He indulged excessively in masturbation throughout his early years and up to and including the present, and frequently introduced his finger into his rectum while masturbating. On one occasion he introduced a piece of wood into his rectum which resembled a penis in its configuration. On another occasion he introduced a rubber tube into his rectum with the opposite end in his mouth and insufflated the rectum with considerable pain accompanied by some erotic pleasure. While nude he used

to stand and observe himself with his penis and testicles tucked backward between his legs so that he would resemble a woman. While in his teens he found himself sexually attracted to young girls and masturbated several of his nieces who were in the age range from 4 to 6. He had several sexual contacts with animals.

He was chiefly concerned about his homosexual experiences. It has already been mentioned that his chief fear and the one which he expressed with the most feeling was that he might be "a homosexual." By this, C. B. meant that he would be actively seeking homosexual contacts. In this manner he did not have the same feeling about some of his other homosexual experiences. These included such things as mutual masturbation and sodomy. He mentioned one homosexual experience in which he was passive and had his rectum insufflated by a man who applied his mouth to the patient's anus and blew air upward. This caused the patient considerable cramp-like pain. In his visit to brothels the patient had relations in the usual manner but in addition performed cunnilingus, and had fellatio performed upon him by a woman. It is interesting that in several of the homosexual acts performed upon the patient he pretended to have been asleep. This is his way of not assuming the responsibility for the act in which he participated. In the course of therapy, when the patient developed homosexual feelings toward this physician, he indulged in free association in which he erotized various parts of his body and created many types of perverse activity which he expressed freely. It was about this time that he developed some homosexual panic symptoms.

DISCUSSION

We have presented a case of auto-fellatio occurring in an overt homosexual with a schizophrenic reaction. One of this man's chief psychiatric problems was his homosexuality which had overt expression on several occasions. In attempting to defend himself against actively seeking homosexual relationships, this man sought to become sexually self-sufficient and so performed upon himself that which he would have liked to perform upon another object choice. The act of auto-fellatio defended him from performing fellatio upon another individual. To the unique organization of C. B.'s personality, actively seeking homosexual contacts is far more distasteful than any other perverse activity.

A large determinant in C. B.'s auto-fellatio is his narcissism. By narcissism we mean the choice of one's own body as the object for gratification of libidinal drives when the ability to differentiate between oneself and objects outside of oneself exists. C. B. is undoubtedly narcissistic, and there is a consistency in his pattern of interpersonal relationships which bears this out. We feel that this strong narcissistic component led him to this rather difficult sexual practice.

C. B. has been in psychotherapy for 18 months with marked improvement. He has been employed regularly at the same position for the last 8 months and suffers less discomfort from anxiety.

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MAINTAINING BALANCE

A. W. GOTTSCHALL, M. D.,*
Farnhurst, Del.

Speaking in a popular sense the function of the nervous system is to harmonize the activities of the human being. If there is a lack of balance in conduct, the indication is that of a sick nervous system, and consequently a sick individual. This is the great lesson to be learned from a serious study of human conduct. It is a definite tendency of future scientific efforts toward human progress. Something out of balance means something inefficient as surely as the same principle holds good in the inefficiency of a mechanical contrivance. Were an absolute organic balance possible in the human, he would be immune to every disease. Unfortunately environmental circumstances disturb this balance and make him constantly susceptible. Man's entire existence, after he reaches maturity, depends on the harmonious functioning of his mind which enables him to get along with other people, to do his work well and to contribute his share to the welfare of society. This he is able to do when he is able to think and to translate his thinking into definite action.

*Senior Assistant Physician, Delaware State Hospital.

When he is not able to do this, he is not well balanced and is subject to a host of difficulties that science is trying to combat. Good health is dependent upon organic balance. The equal distribution of energy into service of the necessary functions where disease and structural defects exist, the balance is disturbed. In the case of a structural defect with more energy than normal being utilized, it is evident that the defective organ becomes not only more active, but more expressive than the normal organ. Every subnormal organ is more plastic and adaptable than normal organs or functions. Under the stimulus and protection of the central nervous system when it has taken the helm, they may become supernormal. What is more important, they may be compensated by other organs or functions with which they are correlated. Moreover, super structures are built which substitute for them, supplementing their deficiencies, thus recalling that man is a congeries of many organs in various stages of evolution and decline. The nervous system, when it comes to power, establishes a set of inter-relations between those which are essential under the impulse of the will to live leaving some to decline and powerfully stimulating others to unfold and develop. By keeping them sufficiently but not too much in exercise, it reinforces both atrophy and hypertrophy. In the effort of the psyche to foster the important organs and functions which it selects for its special care, organic defects may be compensated by excess of nervous activity. Indeed, most compensations are in the psyche, though not necessarily in the conscious field. No one is perfect and hence compensation is necessary for all. It makes for, if indeed, it does not make consciousness itself. Those organs and functions which the psyche can not directly or indirectly control, decay or become stigmata. Where the brain fails to establish a compensatory system, we have all the host of neuroses and psychoses and their myriads of symptoms which comprise psychiatric illness.

* * * * *

The nature of psychiatric illness and the production of symptoms may perhaps be oversimplified on the S-R Principle, where S stands for stimulus and R stands for response. The simplest form of S-R is the Reflex:

When stimuli are carried by sensory nerves to the spinal cord and are relayed to motor nerves, which carry them to their destination where muscular or glandular action is produced, and this response is produced before the stimulus is perceived. This, of course, has not taken the "thinking" brain into consideration.

Therefore, the stimuli reaching the sensory portion of the spinal cord through the sensory nerves are carried by way of the spinal cord to the brain as sensory stimuli, and the participation of "brain" in the S-R complex presupposes 4 fundamental concepts.

They are:

a. *Perception*: The Brain is being bombarded constantly by millions of stimuli coming in over the receptors from inside the body and from the outside world. Most of these it disregards, but *those stimuli that are important enough to be recognized are called perceptions. The process of receiving Stimuli and identifying or recognizing them constitute perception.*

b. *Intellection*: (or Cognition): Perception cannot be formed in Vacuo. The perceived Stimulus must be compared with previously stored information (memories), departmentalized, recorded, etc. *This comparing, regrouping, and registering process is called "thinking"* or cognition, or intellection. The process differs from perception only in degree and not in kind.

c. *Volition*: (or Conation): After a stimulus is perceived and sorted, it must be translated into action. *The resolving of sensations into some sort of outgoing messages which produces motions, which in turn produces acts, which finally crystalize into behavior. This resolving and bringing into a focus is called Will or Volition or Conation.*

d. *Emotion*: There is another part to the cerebration. This part is linked to our memories and hence to our perceivings and resolvings, and it is called Emotion. You can define Emotion anyway you want (many people do) but one thing we do know, i. e., Emotions are infinitely related to our Endocrine function. Thus we have, within the brain, areas for *Perception, Intellection, Volition* and *Emotion.*

A stimulus, being carried over the sensory nervous system to the spinal cord, reaches the

brain by way of the cord through the sensory tracks to the centers of perception and from there relayed to the centers of intellection, and some relays to the centers of emotion, and from the centers of intellection to those of volition, and some from the emotion center to the areas of volition, and from the emotional centers, impulses are sent to and are received from the endocrine system. From the volition center through motor fibres, the response is sent down to the cord and out to that particular part of the body which is to respond to the stimuli. This response is one which has been the result of perception and intellection, emotion and volition, and is a highly complicated type of response to the stimulus received.

In the production of illness and symptoms, perhaps another principle may be introduced, the P-S Principle, where P stands for *personality* and S stands for *situation*. When a personality meets with a situation, two things can happen; it is either a *success* or a *failure*. If it is a failure, it can result either in a *broken personality*, or a *broken situation*, or a *constructive compromise*.

a. When a personality meets a situation, there follows a period of attempted adjustment which can result in success or failure, i. e., maladjustment, and from the failure or maladjustment, there develops on one hand a broken personality, or on the other a broken situation or a constructive compromise which is the second defense. From the broken personality, there may develop psychiatric illness, suicide, etc. From a broken situation, there may result crime, anti-social acts, murders, etc. From the constructive compromise which is the second defense, there may develop an adherence to such arts as music, literature, philanthropies, etc.

Wernicke said that all misfunction could be classified as *quantitative* or *qualitative*, i. e., *too little* (Deficient) *too much* (Excessive), *or the wrong kind* (Distorted). Applying this over-simplified principle to our concept of the areas of Perception, Intellection, Emotion, and Volition, we find the following:

Perception: The *deficient* results in deafness, blindness, etc.
The *excessive* results in oversensitiveness and hyperacuteness.
The *distorted* results in hallucinations.

Intellection: The *deficient* produces stupidity, mental defective, etc.
The *excessive*, the genius, superior, etc.
The *distorted*, delusions.

Emotions: The *deficient* produces apathy, blunted or flat affect, etc.
The *excessive*, elation, euphoria, mania, etc.
The *distorted*, phobias.

Volition: The *deficient* produces inertia, retardation, etc.
The *excessive*, mania, increased activity, etc.
The *distorted*, compulsions.

Whether we approach human problems from a physical angle or from a psychological view point, we always arrive at a point where the two seem to meet. We know that the babe at birth is carrying the effects of race experience in its organism. We know that immediately after birth, the babe commences to absorb effects in its environment. How the organism meets this environmental influence and what its limitations are in the environment is the great question. That question will be answered only when throughout life, the individual's intellectual endowments meet with and harmonize or maintain balance with his environmental demands.

MENTAL HYGIENE AND A CONTINUOUS STATE OF COLD WAR

LOUIS J. KOWALSKI, M. D.,*
Farnhurst, Del.

The value of prevention of mental illness, just like the prevention of other illnesses, is worth many times the cure. Definite progress has been made in the treatment of acute disturbances and the duration of acute mental illnesses shortened. Early psychiatric treatment often checked the actual occurrence of frank psychoses. Some degree of consolation and gratification is certainly available in securing good results from treatment of these conditions. However, the greatest pleasure and satisfaction, that persons in the mental

*Senior Assistant Physician, Delaware State Hospital.

hygiene field obtain, is derived from the knowledge that masses of people are educated and understand how to utilize the mobilized forces and factors that help conserve mental health.

A basic understanding of mental health and and the implementation of principles to protect mental health should be the concern of all people. To most individuals, in spite of cultural, religious, social, economic and philosophic differences, this means prosperous living—which implies a satisfying, self-respecting progression in the human being from the earliest beginning to final glory. It further implies control of one's creative potentialities in economic, financial, social, racial and familial spheres as it relates to other individuals or groups of people or society in general. All factors concerned in this progression of the individual should be clearly and simply defined for easy use of the average individual.

Four-fifths (4/5) of the world's population had some direct or indirect contacts or exposure to actual war or its results. They have experienced or are experiencing the anxieties, fears and terrible uncertainties associated with war. They have some knowledge concerning the various facets of carrying on war, the needs and goals, and also develop a philosophic attitude toward the hated enemy and the beloved allies. All are willing to make some sacrifices to attain their objective.

Since most people have some familiarity with some aspect of war and are conversant about war generally — an approach to Mental Health and Mental Hygiene in terms of logistics and war may have the most favorable consequences especially as an educational guide that would alert and attract peoples to the general problems of conservation of mental health and the prevention of mental illness.

It may seem at first paradoxical to speak of mental health in terms of a continuous state of cold war but even a very superficial glance and study of terminology applied to life in general leads one directly to phrases and words which signify a battle or war: that is, forces in conflict, struggle, rivalry, competition, resistance, destruction, retreat, offense, wounds, trauma, scars, tension, power, defeat, victory, surrender, hostility, truce, peace, safety, security, striving, mobilization, disarmament, etc.

A well planned concerted action by a national (preferably) or state organization to reach the maximum number of people with an agreed upon terminology, definition and formulation by all interested individuals, groups, societies, associations and conventions in mental hygiene could be inaugurated. The object would be to use words and terms that everyone will understand and would apply correctly for individual and mutual benefit.

Since the human being is an indivisible biologic unit, a new word should be coined and adopted for general use — it should mean just that and not a part or division in organic and psychic. The new word should convey and be symbolic of the indivisible biologic unit. Once the word is adopted, such factors as heredity, environment, constitution, culture, society and physiological and psychogenic functions including the intangibles could be manipulated on the principles of logistics. There is no one word that means and describes an individual with healthy body and mind except by implication, that is military personnel such as soldier, sailor, marine, etc., who are accepted for military services after a careful and complete examination. However, the Latin phrase — MENS SANA IN CORPORE SANO — has been widely used for descriptive purposes and motto. Taking the first letter of each word in that phrase — a new word MSICS (which could be shortened to MSIX) is available which would describe the indivisible biologic unit adequately.

Since this reads definitely like an utopian plan — the application of logistics which in itself is universal should lead to the least resistance in utilizing the material for rapid advance in fields of mental health. Simply stated it should work like this. A prosperously living individual would rate an ascribed or established standard value. Heredity, constitution, environment, socio-economic-cultural factors and intellectual endowment would be given definite numerical positive values. All new experiences, encounters and maneuvers that an individual battles through are given a minus value. Depending on the resourcefulness in the use of the positive values to conquer and assimilate the negative values,

a balance is attained. The final result being still a prosperously living individual providing he is victorious in most of his life encounters.

This is a rough idea, which can easily be elaborated into volumes but should not. If it is to reach the masses of people it should be presented in a short, clear and concrete form. An abstract idea such as mental health or mental hygiene can be conveyed to and understood by the average individual if it is converted into a concrete symbol.

CONTRAINDICATIONS FOR ELECTRIC SHOCK TREATMENT

The Need For Re-evaluation

H. GEORGE DE CHERNEY, M. D.,*
Farnhurst, Del.

Certain physical conditions have long been looked upon as contraindicative of electric shock treatment (EST) and, as a result, there are still some clinicians who are reluctant to submit these so-called "poor physical risks" to EST even though it is therapeutically indicated. However, more recently, studies of case histories have been reported where no additional pathological changes have occurred in such patients as a result of EST. The two cases which will be reported here give added support to the growing belief in a more widened use of this type of treatment.

Case #1. This is the case of a 62-year-old widow who was previously admitted to the Delaware State Hospital in 1946 where she remained for five months. At that time a diagnosis of manic-depressive, mixed type was made. She received EST, made an uneventful recovery and was discharged from the hospital. She was getting along quite well until five weeks prior to her second admission in February, 1951. At this time she was referred to the hospital by her family physician because of her numerous physical complaints, her state of depression and the possibility of suicide. During these five weeks she became withdrawn. On admission she presented the picture of an individual who was extremely anxious and tense and slowed up in her thought processes. There was no spontaneity during the interviews; however, upon careful questioning she talked about some trifling misdemeanors in her past about which she felt very guilty. She gave the usual physiological components of depression, namely, inability to sleep, loss of appetite and constipation. She stated that her spirits were very low and, although she denied suicidal ideas, upon questioning it was apparent that she was preoccupied with this thought. The diagnosis of manic-depressive, depressed type was made and preparations for EST were initiated which, for all patients over 40, include an EKG, a lateral x-ray of the thoracic spine and the other routine laboratory examinations, urinalysis, etc. The EKG was read by our consulting cardiologist who reported a "left bundle branch block signifying coronary sclerosis with myocardial damage or previous coronary thrombosis." The seriousness of the mental status was weighed against the cardiac disturbance and, in view of the danger of the psychotic condition and its effect upon the heart, EST was decided upon. This patient responded well to a course of 7 electric shock treatments. At the end of the treatments she began to eat well, sleep well and externalize her interests to an adequate degree. She began to socialize in the clinic and was again on her way to an uneventful recovery. Following her last shock treatment another EKG was made showing essentially no change in comparison to the tracing taken before treatment. She remained in the hospital for two months. Since discharge she has been seen in follow-up interviews and is making a good adjustment at home.

Case #2. This is the case of a 64-year-old widower who had been admitted to the Delaware State Hospital on two previous occasions in 1936 and 1945 for a period of three months on each hospitalization. On each admission a diagnosis of manic-depressive, depressed type was made. The patient received EST, responded well and was making an adequate adjustment until January, 1951, when his family physician sent him to a general hospital for a left hemiplegia due to a cerebral thrombosis. An EKG taken at that time showed a "tendency to right bundle branch block" and the tracing suggested "definite myocardial damage." Following this episode he became extremely depressed, stayed in bed continually, could not eat or sleep and cried on numerous

*Senior Assistant Physician, Delaware State Hospital.

occasions. Because of the good response to EST on previous admission, his family decided to have him readmitted in March, 1951. On admission he sat with his head down, his brow furrowed and he showed a tremendous amount of psychomotor retardation. He felt that he was not wanted by his family and that he was alone. He said that he had committed a sin in going out with other women, even though his wife had been dead for some time. He had lost 30 pounds in a short time because of the anorexia and he said he felt "blue" all the time. He was oriented in all spheres and his memory for past and present events was good. There was no evidence of any organic mental disturbance. Because of the depth of the depression, it was felt that EST should be initiated immediately even in view of the residuals of the cerebral vascular accident and EKG findings. He was given a course of 5 shock treatments and responded well. The good appetite he had had prior to his illness returned and there was no evidence of any depression either physiologically or psychologically. He was discharged after two months and has been seen in subsequent interviews. He was able to return to work and make an adequate social adjustment.

SUMMARY

The purpose of this paper has been to present two cases in which EST was administered successfully even though there were severe organic disturbances present. The absence of further organic damage after EST was demonstrated by electrocardiographic and physical examination following the course of treatment. Evidence from the two cases cited and those reported elsewhere indicate the need for re-evaluating the contra-indications of EST.

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A CASE OF EPILEPSY

ROY E. REED, M. D.,*
Delaware City, Del.

In a chronic disease condition like epilepsy the therapeutic program must be planned to extend over a prolonged period, often many years. During this time the responsibility for carrying out the treatment program cannot safely be left to the judgment of the patient or his family. A schedule of follow-up care is essential and must in large part be assumed by the physician who accepts the patient for care.

The therapeutic program for epilepsy involves the use of methods and techniques of both internal medicine and psychiatry. For the great majority of patients there is no need for a specialist from each field, and the results are most satisfactory if a single physician assumes responsibility for both types of work. He must be willing and able, however, to arrange his schedule to allow from forty-five to sixty minutes a visit for each patient; shorter interviews are rarely adequate during the early phases of treatment. This amount of time is necessary because the physician must care not only for specific medication but also for the physical and emotional needs of the patient as well. In work of this type the cooperation of a medical or psychiatric social worker is of great assistance. It is obvious that if such time-consuming attention is to be given to any large number of patients some modification of the present-day practice of medicine will be required. No physician working on a fee-for-service basis can afford to give this type of care to any but the wealthy in a community. However, the problem of time appears more feasible when considered in the light of the several years over which it may extend. To a majority of patients who have been carefully studied at the beginning, satisfactory follow-up care during the first year can often be given through weekly interviews. In the second year of treatment, appointments at monthly intervals may suffice. Actually, the problem of time is not difficult to arrange. Less easy to solve is the problem of finding physicians whose interest and training permit them to do this type of work. With patients who already suffer from marked personality maladjustments when first seen, the responsibility for medical care may belong to the psychiatrist. And no matter how skillful the physician or psychiatrist may be in handling the problems of the epilepsy itself, the end result often depends on circumstances in the patient's environment that are beyond his control.

*First Assistant Physician, Governor Bacon Health Center.

The attitude of other members of the patient's household, the difficulties at work and at school, the financial problems of meeting the cost of medical care, in addition to family needs, all these have a direct bearing on the success of treatment and the outlook of the disease.

Although a program of preventive work with epileptic patients will in the course of time reduce the number requiring permanent custodial care, there will always be a need for institutions where a type of care can be provided other than that available in the physician's office, out-patient clinic, or the home. By the very nature of the causes of the disease, some individuals will have suffered from such extensive brain damage as to preclude normal living in a community. The type of institution most commonly needed falls into the class of so-called "convalescent" homes.

Such a "home" is the Seizure Control Unit at the Governor Bacon Health Center. Here the epileptic patient lives as a member of a group, away from his former environment with its irritations, frustrations and disappointments, and under direct psychiatric direction and supervision. Here facilities are available not only for medical and psychiatric care, but also for education, normal play activities, and the development of special interests. Health supervision, special diets, modern medication and intensive psychotherapy are available as called for. The duration of convalescent care will vary with the severity of the problems needing correction; in some instances a period of from three to six months will suffice to establish treatment and modify the child's attitudes toward his disease and toward his former environment.

Such a child patient is M. P., a white female of seven years who entered the Center in March of 1950 from her parents' home near Dover, Delaware. She is the only child of her mother's second marriage, and has two-half-siblings, aged 26 and 28. Both parents and the two brothers have overindulged M. to the point where she is a serious behavior problem. Her first year at school passed uneventfully; during the second year her teacher reported a lack of concentration, disinterest, irritability and epileptic convulsions. All these became rapidly worse, so that M. was reported to be having as many as two convulsions a day, and in October was removed from school. Her mother reported very few "spells" at home and wondered whether the teacher was afraid of the spells and was exaggerating the report of the trouble or whether M. was really having most of her trouble at school. Her adaptation to her new "home" at the Center was at first very stormy; she was intensely homesick, spending much of her time in wailing and self-pity; visits from her oversolicitous parents made her worse and generally had a devastating effect on her. Her adaptation was passive, dependent and controlling. She was adept at getting the other girls to do her assigned chores; she connived to be accepted as the darling of the ward, and had many admirers. After a period of observation she was found to have nothing that could be considered true epileptic phenomena, but did make a show of having spells of a hysteroid or semi-malignering nature, rather opportunistically exhibited. She was removed from the seizure unit to the cottage system to live, but here a rather rigid, demanding housemother failed to make allowances for M's excessive dependent needs, she in turn refusing to accept the responsibilities of group living; she had "spells" and eventually had to be returned to the seizure unit. Another attempt to promote M., this time to a warmer and more accepting type of housemother, proved successful; M. was taken in by the other girls, she was accepted as a person in her own right, with the privileges and responsibilities of a growing person; she found herself happy, contented and dignified. There have been no "spells" or other epileptic phenomena and her anti-convulsant medication has gradually been reduced to a trifling minimum.

THE NEED FOR MENTAL HYGIENE

A Case Report

CALVIN SETTLAGE, M. D.,*
Delaware City, Del.

Mental hygiene can be defined as the science dealing with the preservation of mental health, or to put it in another way, with the prevention of mental illness. Preventive psychiatry quite naturally has as its major focus the

*Child Psychiatrist, Governor Bacon Health Center.

childhood period, since it is generally accepted that the experiences and influences of this period are vital in the determination of the character structure, the personality traits and the degree of maturity seen in the individual as an adult. Our knowledge and understanding of the principles governing healthy mental and emotional development broadly speaking has been derived from three main approaches: (1) through the diagnosis and treatment of emotional disturbance in the adult, wherein the childhood period is viewed in retrospect, (2) through the diagnosis and treatment of emotional disturbance in the child, wherein the cause and effect relationships are seen in a much closer chronology and at times almost in situ, (3) through the observation of the normal child in the normal environment, wherein the interaction of the child and the environment is seen to result in preservation of mental or emotional health. It is the purpose of this paper to illustrate the need for mental hygiene through a case report demonstrating the diagnostic evaluation of an emotionally disturbed child. A further goal is to acquaint the non-psychiatrically trained observer with the manner in which data derived from interviews with parents and child is interpreted in understanding the meaning of symptoms and in making a formulation of the psychopathology. In view of the purpose, as defined above, there will be no attempt to present all of the data available regarding this case since it would only serve to obscure the thinking employed in arriving at the major diagnostic impressions.

Eugene is a 6-year-old white boy referred to the Center with the symptoms of running away from home to a nearby woods, setting fires in the same woods, general disobedience and mischievousness, wetting himself, urinating on the floor at home, nervousness at night with crying and vague fearfulness, and nightmares with screaming as if afraid.

Upon examination the patient is seen to be a physically healthy, attractive boy, adept in motor activity and well socialized. He attends kindergarten and has not been a serious problem there. Psychological testing shows high average intelligence with good thinking ability and good perception of the reality world. He is somewhat inept in language ability, has a short attention span and shows a tendency to give up easily. In the psychiatric interview he related readily but somewhat apprehensively. He was alert and questioning. He produced a poorly structured watercolor painting and was quite anxious because it was rather messy. The subject of the painting was a house. When asked to tell a story about the people who lived in the house he replied, again with considerable anxiety, "I can't tell a story about the family," the implication being that he would be talking about his own home. A short while later the examiner paraphrased the patient's difficulty by talking about how "we want to help boys and girls who get all mixed up inside and do things which get them in trouble." The patient immediately responded "that's what I do." In a subsequent contact on the playground he stated resentfully that if his mother and father didn't come that evening to take him on a weekend pass, he'd run to the woods and drown himself in the creek when he did get home.

Eugene was adopted at age 4 months, his parents having decided before their marriage that they would adopt a child if they had none of their own after five years of marriage. Father is a semi-skilled laborer and mother a housewife. Both parents are between 35 and 40 years of age. Mother is a highly religious person judged to be of average intelligence who is sincere and well motivated to be a good parent. However, at this point she is anxiously tense and has given up trying to control the patient, verbalizing her belief that his difficulty must be due to his heredity. She reveals in many statements that she has no great confidence in herself as a parent, and has always leaned heavily on advice from others, sometimes authoritative and often not. Father is also of good intelligence and with good intent as a parent. He is not as despairing as the mother, but does reveal some resentment towards the boy. He complains that although mother tells him he should play with his son, yet when he does so, the boy usually drifts away from father into playing with other children. At present the parents have a completely dependent attitude in seeking help from the Center, but nevertheless are eagerly cooperative. They both state that they are socially and sexually compatible.

Three years after the marriage mother lost a child through a miscarriage, and gained the impression that she could not get pregnant again. The patient was adopted a year and a half later. Subsequently mother did become pregnant, however, and there now is a brother age 20 months. Interestingly the patient apparently sensed the parents' desire for another child and was praying for a baby brother before mother knew she was pregnant. He has been openly resentful of this younger brother and the parents have tried to cope with the sibling rivalry by following a rule of "no partiality" giving the boys similar toys, candy and other material rewards.

The patient was examined psychologically at age 16 months and according to the mother was reported as normal but overactive. Mother states that she was advised to be strict with the patient and not let him get away with anything. She volunteers that in retrospect she may have been too strict with him. Both parents report that he was difficult to manage from the age of 2 years on, "always getting into things." He was not a serious problem, however, until about two years ago (which correlates in time with the beginning of mother's pregnancy). At that time mother, who had kept the patient under her constant, close surveillance before then, was unable to continue doing so because of the pregnancy. He then became unmanageable and began running to the woods. Since that time, increasing strictness and discipline has resulted in increasing misbehavior with the symptoms mentioned in the opening paragraph of the case report.

When interviewed, the parents also report a sexual problem in that the patient is known to have engaged in sex play consisting of mutual masturbation with older boys. This occurred about 20 months prior to admission. Since then he is known to masturbate frequently and regularly. It was decided that father should deal with this problem and he did so by telling Eugene that "God gave you that thing to 'pee' out of and if you use it for anything else, he may take it away from you."

The parents had been informed by the adoption agency that the patient should be told at some time that he was adopted. Mother began telling him he was adopted vaguely and indirectly through prayers. She could not recall the specific words used. Later, when the patient was 4 years of age and just before baby brother was born, she took the opportunity while reading to him from a book which had babies in it to tell him he was adopted. She explained that "God took your mother and father to heaven and we wanted a little boy, so we came and got you from the people who were taking care of you." Eugene made no comment and asked no questions.

In the process of diagnostic evaluation we can turn our attention first of all to the symptoms themselves. The running from home, the fire-setting, the disobedience, the wetting of himself and the urinating on the floor, all seem to be hostile expressions of rebellion against parental authority. The night fears and nightmares suggest that he is afraid of retaliation for these hostile feelings and destructive impulses. The remark about drowning himself in the creek is not only attention getting but also represents the turning of his hostile aggression towards himself. The continued masturbation seems to reflect both a rebelliousness in doing the forbidden and a compulsive need to prove himself unharmed sexually and able to win out over the implied threat of castration. If we now inquire as to the reasons for all of these symptoms of hostile aggression, we can discern a number of contributing causes: (1) The disciplinary strictness and excessively close supervision carried out apparently with authoritative permission. (2) The vagueness and indirectness accompanying the patient's learning of being adopted, which more than likely made him feel that there was something wrong with being adopted, since the parents couldn't face it more directly. (3) The subsequent arrival of a baby brother who is the real child of the parents and not adopted as is the patient. (4) The handling of the sibling rivalry with such complete impartiality that the patient felt there was no compensation for being displaced from the center of attention by the younger brother. (5) The handling of the masturbatory problem in such a way as to pose a threat to his masculinity and to his physical well being.

It does not take too much imagination to formulate what these various factors added up

to in the child's mind. Being adopted would seem to be a distinct disadvantage in maintaining his status with the parents and in competing with baby brother for their love and affection. Also he probably interpreted the disciplinary strictness, the lack of individualization in dealing with the sibling rivalry and the threat implied in the taboo against masturbation as evidence of a lack of understanding on the part of the parents, and probably also as evidence of parental rejection. Add to this the perplexity and confusion engendered in trying to understand such an abstraction as being adopted, and such a fear laden and shrouded subject as sexuality, and we see a good deal to account for a mentally and emotionally disturbed child.

Returning to the opening remarks regarding mental hygiene, we see that in this case the diagnostic evaluation serves to point up the need for preventive aid. Particularly with parents such as these, who are not so much emotionally disturbed or inadequate as they are insecure, proper dissemination of knowledge and guidance may be of great value. Help with the difficult problem of employing discipline in such a way as to gain cooperative self-sufficiency instead of rebellious self-assertion; with the problem of explaining adoption in a non-traumatic manner; and with the problem of giving lucid but non-threatening and non-provocative interpretation regarding sexual experiences could have been of great hygienic value to these parents and this child. Although a good deal is known about both the state of mental health and the state of mental illness, the problem of application of this knowledge in a preventive manner is still for the most part unsolved, and accordingly merits the serious thought and attention not only of psychiatrists but of the entire medical profession.

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SODIUM AMYTAL ADDICTION WITH AN ACUTE TOXIC PSYCHOSIS

JULIUS FECHNER, M. D.,*
Farnhurst, Del.

The patient, a white male, 34, father of a two-year-old son, came to the Delaware State Hospital as a voluntary admission on an emergency basis. His mother had informed the Director of the Mental Hygiene Clinic that patient was using daily up to 20 capsules of Sodium Amytal, each containing 3 grains of the drug. He managed somehow to get refills of an old prescription and spent between $1.25 and $1.50 per day over a period of several years, skillfully hiding his addiction from his common law wife and from his mother. The patient, whose work record has never been too good, had spent the last four months at home because he was always drowsy and tired. The patient has been referred to the Mental Hygiene Clinic by his family physician in 1941, the reason being the young man's extreme shyness in the presence of strangers, his fear of meeting people and of talking to them and the subsequent use of alcohol to steady his nerves.

The social history, as obtained at that time, disclosed that patient's father, a butcher, was a chronic alcoholic who abused his wife and two sons when he was intoxicated. The family life was unhappy because of this and there was also rivalry between the elder and younger brother, our patient, for their mother's affection and attention. The patient was a normal, full-term infant. When 12 months old, he was severely ill with bronchitis and, according to his mother, had been nervous ever since. He started schooling at the age of 6 and quit when 15 without graduating from the 8th grade because he was afraid of and hated arithmetic. When 20, he took a correspondence course in advertising but never could get a job in that field because he became tongue-tied whenever he appeared for an interview. The only job he could then get was to prepare walls for paperhanging. His employer was his uncle, against whom patient showed great hostility instead of gratitude. Patient was enuretic till the age of 8 and still chews his nails. After a preliminary inter-

*Acting Senior Assistant Physician, Delaware State Hospital.

view with a psychologist, patient failed to keep his appointment with a psychiatrist. He reappeared at the Mental Hygiene Clinic in 1943, stating he had been classified 4F because of psychoneurosis, that all his buddies were "in" and he was unhappy to be left out. He, therefore, requested a certificate from the Mental Hygiene Clinic to the effect that he was eligible for Army service.

He next came to the Clinic in 1950 with a statement from his family physician that patient was a psychoneurotic who was unable to work or sleep and who was receiving medication for his nervous condition. Yet again after a preliminary interview, during which psychometric tests were done, the patient failed to keep an appointment with the psychiatrist. Nothing was heard of him until his mother requested by phone that patient be admitted on an emergency basis because of severe intoxication due to the prolonged use of increasingly large doses of sodium amytal.

It would seem that this young man, unable and unwilling to tackle his problems, first looked to alcohol for solace and succor. Then when introduced to sodium amytal, he came to depend on its "stronger and longer action" for relief from unbearable tension.

Upon admission, the patient's sensorium was clouded and speech was slow and thick. Questions had to be repeated again and again to get some response.

Patellar reflexes were barely obtainable. Plantar, cremasteric, abdominal reflexes were not obtained. Patient was unable to stand erect without toppling over. His gait was ataxic. The pupils were mydriatic and responded poorly to light and accommodation. The corneal reflex was abolished bilaterally.

Upon admission the patient's blood pressure was 138/100. Pulse 78; heart and lungs were negative. Urea nitrogen 19. Cephalin test negative.

After administration of 50 cc. of 50% glucose, plus caffeine, sodium benzoate, plus 10 units of insulin, plus 200 milligrams of thiamine hydrochloride, patient answered a few simple questions but soon again became drowsy. The above medication was kept up for the next four days at the rate of 3 injections per day. 10% glucose in saline was given in repeated doses of 500 cc. to prevent dehydration. As a withdrawal reaction, patient had 4 convulsive seizures of the grand mal type and it was necessary to administer 1½ grains of dilantin, 3 times a day, for 6 days to cope with this symptom. On July 10, 1951, 50 cc. of liquor cerebro-spinalis, were obtained; the manometric reading was 22 milligrams of mercury; the laboratory findings of the spinal fluid were within physiological limits. Gradually the sensorium cleared and the neurological responses are returning to a normal pattern. After visiting the patient on July 16, 1951 for the first time since his admission to the Delaware State Hospital, the common law wife remarked that her husband seemed "quite normal" to her, spoke clearly and relevantly about his situation and expressed his desire to return home. Moreover, he promised never again to take the capsules, the use of which he managed to hide from the common law wife and his mother.

RESUME

A 34-year-old man has been under observation at the Mental Hygiene Clinic of the Delaware State Hospital. He showed many neurotic traits but never submitted to a psychiatric treatment. For the past few years he took increasingly large doses of Sodium Amytal which he obtained as refills of an original prescription. He was admitted to the Delaware State Hospital on an emergency basis with the symptoms of an acute toxic (exogenous) psychosis. An outline of diagnostic data and therapy is given.

SYPHILIS IN NEGRO PATIENTS

C. LAWRENCE R. SOUDER, M. D.,*
Farnhurst, Del.

In the group of luetic patients admitted to mental institutions the classification of syphilis includes: (1) meningeal; (2) Vascular or meningeal; (3) parenchymatous types. Two other forms include (1) asymptomatic neurosyphilis; and (2) gummatous neurosyphilis.

Neurosyphilis, as brought out in recent literature on the subject, has apparently been increasing in the negro population and bone and visceral syphilis seems to be decreasing. The effect of race also presents some different clinical manifestations. In comparison with the white population, for instance, there has

*Assistant Physician, Delaware State Hospital.

been noted an earlier age of onset of the infection.

Invasion of the nervous system by the treponema pallidum occurs in the early weeks or months of the infection. Syphilis may be diagnosed even in the complete absence of clinical evidence of the disease by means of routine examination of the cerebro-spinal fluid.

In a group of 136 patients, all of whom were admitted to this hospital between January, 1945 and July, 1951, it was found that syphilis was either a major or contributing factor of their psychosis. In the majority of these cases the syphilitic involvement of the central nervous system was the direct cause of their psychosis.

71 patients of this group had general paresis with positive spinal fluid Wassermann, colloidal gold curve and other spinal fluid findings. 11 patients had cerebral syphilis and 1 patient had tabo-paresis and 54 of the admissions during that period had vascular lues.

Specific therapy consisted of penicillin, fever treatments, arsenicals (including mapharsen for vascular lues and aldarsone for general paresis) and bismuth. Every luetic case received a minimum of 10 million units of penicillin as soon as a diagnosis had been confirmed by laboratory results. 20 million units were given to the particularly acute or serious cases. Repetition of courses of penicillin was carried out each year in cases resistant to treatment.

Four of the cases of vascular lues responded by having negative serology after receiving penicillin treatment alone. 26 cases received 1 or more courses of fever therapy in combination with Aldarsone after having had their courses of penicillin and bismuth. In these cases they were given the injection of Aldarsone intravenously after an injection of 50 cc. of 50% glucose intravenously at the height of the fever, once weekly, during the hyperpyrexia treatment.

The improvement in the psychosis was often found to parallel the blood and spinal fluid findings. The shorter the duration of the paretic symptoms, the better were the results.

A few patients required electro-shock treatment in addition to the combination of penicillin, fever, arsenicals and bismuth. The results of treatment depended also, to a large extent, on the type of psychosis present prior to therapy.

Penicillin, in combination with the heavy metals and fever therapy, exerted a favorable effect on the spinal fluid abnormalities of an appreciable number of these cases. In several cases, the complement-fixation (Wassermann) reaction became negative, and what was more important, there was improvement in the cell count, protein content and colloidal gold curve in the spinal fluid of the patients who were benefited by the treatments.

Of the entire group of 136 patients, with a diagnosis of some form of syphilis, 84 of this number today are out of the hospital, either on Trial Visit or have been discharged. All of them were advised to receive follow-up treaments and check-up at the Delaware State Hospital out-patient clinic, one of the state clinics, or from their private physician. A very small number of patients were referred to other hospitals, 11 patients died while in the hospital, several of these from intercurrent infections.

It became possible to discharge some of the cases who were on Trial Visit and free from psychosis.

In summary, penicillin alone has been found sufficient treatment for a number of cases of syphilis. In a large number of cases of neurosyphilis, penicillin and a combination of fever therapy with the arsenicals (mapharsen and/or aldarsone) and the heavy metals have given good results.

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Physio-Therapy Department (including Hyperpyrexia Treatments)—Delaware State Hospital.

ALCOHOLISM

WILLIAM A. BYRNE, M. D.,*
Wilmington, Del.

One of the most pressing needs confronting the nation at this time is the problem of alcoholism. It has been estimated that there are over 3,500,000 alcoholics in the United States. Industry has lost a minimum of 228,000,000 work hours in the past year because

*Part-time Psychiatrist, Delaware State Hospital.

of this problem. The first admission rate of alcoholic psychoses was 10.6 per 100,000 population in the mental institutions of one of our largest states. Numerous highway deaths are the result of driving while under the influence of alcohol.

The problem is a vast one and has many ramifications. Moral issues, social issues and economic issues have been raised to explain the alcoholic habit. We find some who say it is sinful to drink and the person presumably must be just plain bad. Some excuse the drinking because of poor housing, others on financial grounds. Not too many years ago the government attempted to solve the problem by legislation, namely, the 18th Amendment or what has been more commonly known as the "noble experiment." While there is no doubt that moral, social and economic issues result from the abuse of alcohol, it seems unreasonable to assert they are the cause.

In recent years we have gradually accepted the concept that Europeans have known for years, that alcoholism is essentially a medical problem. Since it is a medical problem, as physicians, we are faced with the choice of methods of treatment.

From numerous studies of these individuals, careful investigation of life histories and various reasons given by patients for drinking, it is apparent there is no single direct cause. One also concludes that alcohol satisfies some deeply-seated psychological need. This need for the most part, seems to be a relief of tension caused by an internal conflict. The alcoholic has a low tolerance for anxiety and frustration and must alleviate this anxiety. It has been known for centuries that alcohol makes one feel better and since it is so easy to obtain and it is socially acceptable to drink, at least moderately, it is no surprise that alcohol has become the chief vehicle to relieve the tension and anxiety. The alcoholic, contrary to public opinion, is not the hale and hardy individual he is often depicted. In reality, he is essentially the dependent individual, one who is afraid of life and life's problems and who needs help but at the same time resents it. In fact, the alcoholic is in most cases a compulsive individual — the alcoholic habit in itself, being a compulsion. Many alcoholics are depressed and have learned that the alcohol makes them feel better, usually resulting, however, in the classical morning hang-over. It would seem as if the alcoholic drinks to forget, usually not some external factor, although this factor in some cases is frustrating enough that it must be remedied before any cure is affected, but some tension or anxiety caused by unconscious wishes or desires. In turn, the alcohol releases inhibitions, dissolves the conscience so to speak, and allows unacceptable thoughts and impulses to enter consciousness. These the individual cannot tolerate, so he resorts to more alcohol and a vicious cycle is started.

Alcohol is not the only method of escape an individual may use, hence, the need for careful use of drugs in the course of therapy. To what avail is the cure of alcoholism if we leave the patient addicted to drugs? Also, it is well to keep in mind that the alcohol may mask a severely disintegrated personality and its abrupt withdrawal with no support may precipitate a latent schizophrenic reaction.

Since the physiological effects of alcohol are well known, no mention will be made of them here.

The treatment of the alcoholic might be divided into three phases: (1) the acute state of intoxication — the length of time and amount of alcohol involved will determine whether simple sedation or more radical forms of therapy are needed; (2) the physical or repair stage caused by lack of vitamins are well known and need not be repeated; (3) the alleviation of the underlying cause. It is this last phase which must be effectively handled if we are to make any permanent headway in helping these individuals.

Regarding treatment, a few generalities should be borne in mind. First, treatment of alcoholism is a long, drawn-out affair. It is full of ups and downs and at times not too rewarding. The physician for his own peace of mind should understand this or he may become too frustrated to be of any help to the patient. I am sure many physicians have worked hard with these individuals, have been taken in by their apparent sincerity and pseudo-insight, only to learn that the patient stopped at the first bar on leaving his office. Second, the physician should know why the patient wants help — is this wish sincere, or

is it forced upon the patient? Moralizing about the problem is fruitless. The patient will have heard all of that before the physician sees him. His self-esteem will be low and any sermon will only generate further feelings of guilt with anxiety to which he will probably react by resorting to the best method he knows of relieving this state, namely liquor. Third, generally hospitalization in a psychiatric institution or a psychiatric ward in a general hospital is the optimum place to institute treatment. It is assumed, of course, that in such a place the personnel is trained and sympathetic with the problem. Here the individual is removed from the environment which has been instrumental in bringing his anxiety to the point where he cannot handle it. He can relax and treatment of a psychiatric nature can be instituted.

Psycho-therapy should start from the time the patient is first seen. Naturally, in the first phase or phase of intoxication the only psychotherapy is that of reassurance. Many are in a panic state and any indecision on the part of the physician or personnel increases this panic. Keeping in mind that a great many of these patients really do not want help other than recovering from the hang-over, the therapist will be called upon to use all the ingenuity he can muster. It is, of course, assumed that the therapist is really interested in the patient. If for some reason the patient evokes too much anxiety in the therapist, then he should be referred to someone else. Feelings of pity and condescension must be avoided. Above all, there is no place for the use of threats, real or implied. The patient must be made to feel he is an individual, who is ill and the therapist is understanding and wants to help.

During the course of the interview the therapist will have to make some plan. Certain individuals will do better in group therapy, while others will continue to need individual attention, or a combination of both may be used. The type of therapy will depend to a large extent upon the patient and his needs, the amount of time available and the orientation of the therapist.

Many cases, upon leaving the hospital should be seen on the outside either by a psychiatrist or at a psychiatric clinic. Rarely a patient stays in a hospital long enough to affect a cure. Usually, the most that can be achieved is to start the patient going forward.

The nature of the treatment will have to be further fitted to the individual. Some cases, carefully selected, may benefit by the aversion or conditioned-reflex method. This should be accompanied by at least superficial psycho-therapy, if we expect the patient to have any permanent results. In some cases therapy in the nature of psycho-analysis may be necessary. It would seem, at least at this stage of our experience, the patient must learn to accept the fact he can no longer use alcohol — in other words, his first drink is his downfall. It would be wise to make full use of Alcoholics Anonymous, a group of former alcoholics, who have joined together to keep themselves and others suffering from the disease, in rehabilitation. However, all forms of successful treatment will depend on the reeducation of the individual.

In conclusion, alcoholism is a problem of prime importance to the physician. It is essentially a medical problem, not a moral one. It is symptomatic of a deep seated personality disorder, in which the best hope of cure lies in repair of the Personality defect.

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AN ADOLESCENT BEHAVIOR PROBLEM IN A GIRL

O. EUGENE BAUM, M. D.,*
Farnhurst, Del.

Adolescent maturation is difficult enough to understand in the relatively normal girl, but where there is maladjustment and delinquent behavior, the problem becomes extremely challenging and often most difficult to handle. We are frequently confronted with just such problems at the Mental Hygiene Clinic of the Delaware State Hospital.

The following case report is being present-

*Part-time Psychiatrist, Mental Hygiene Clinic, Delaware State Hospital.

ed therefore to demonstrate how one of these problems was handled in cooperation with the staff of the Woodshaven School for Girls.

J. B., a 14-year-old white girl was first referred to us by the court in December 1949 for incorrigibility. She had violated probation, stayed out late at night, and actively rejected the home situation.

The second oldest of four female siblings, her present difficulties started following the separation of her parents during the previous year. J. B. found the situation unbearable. "I don't like to stay home because I can't get along with my parents. They hate each other. My father often says that I 'should go to the dogs' and threatens that I will 'end up in a reform school.'

J. B.'s mother had been a "graduate" of the reform school for girls. She was there for three years, and on leaving in 1930 she married. The court referral described this mother as an "immature, unstable woman with depressive spells. When she got drunk (which was often) she was entirely out of contact with reality. She can fly into rages, tear clothes and become wholly unreasonable."

The father had always been a chronic alcoholic but at the time of J. B.'s referral he had joined Alcoholics Anonymous. He was strict with the girls, but his own behavior was far from exemplary. He often came home drunk openly demanding sexual intercourse with his wife.

The developmental history of J. B. is sparse (not taken by our social service department) but presumably her birth was within normal limits. However, she was described as always being a nervous child. She was restless, had nightmares and enuresis. The latter resulted in considerable conflict with her mother and increased the feeling of rejection. J. B. often turned to the father for support and he apparently was more understanding. Two incidents — double pneumonia at age 4-5 and an appendectomy at age 7 — stand out because she received more attention at those times, especially from the mother, than at any other time. She often clenched her fists and talked and jumped during sleep. There was also occasional sleepwalking. In school J. B. was often confused and did poorly. (See psychological summary) This further increased her feeling of inadequacy.

In the initial psychiatric interview she was seen to be a rather attractive girl of slender habitus (small hips, average bust) whose appearance was somewhat marred by two missing upper front teeth. Her dress and cosmetic makeup as well as her manner were seductive in nature. She verbalized hostility freely but in an ambivalent manner and without adequate affect. At times she giggled in a silly way. Her thinking and judgment were defective. She tended to be circumstantial. But she did recognize that her home environment was not good for her and wanted to leave. There were obvious manifestations of a severe personality disturbance with weak ego integration, severe though spotty superego, and strong instinctual drives. Ambivalence, inadequate ego ideals and sexual confusion were paramount.

Psychological examination revealed low average native endowment with marked inability to make practical judgments as well as difficulty in finding hidden relationships in her environment.

The Electroencephalogram (not available at the initial staffing) demonstrated fast frequency low voltage waves which dominated the tracing. Also altered cortical excitability was in evidence. The electroencephalographer recommended suppressive therapy.

At staff conference it was agreed to recommend that J. B. be removed from the home environment and either placed in a good foster home while receiving treatment at the clinic or that she be sent to the Governor Bacon Health Center, where maladjusted children were treated up to the age of 16. However, at the specific request of the father the court agreed to send her to Woodshaven School for Girls (delinquent type). This school then sent her to us for psychiatric treatment with the note that "she was extremely loud, talkative and wanted to be the center of attention."

During the first 13 visits to the clinic on a weekly basis, J. B. was seen in group therapy together with 5-6 other girls from Woodshaven. During many of the hours she was very exhibitionistic, monopolizing the discus-

sion, acting silly and often in a disorganized way.

She tended to act out sexual phantasies and often started the discussion around sexual topics. Once she sucked on a balloon with ecstatic glee and when it was suggested she might like the therapist to bring her a milk bottle and nipple, she said she was thinking of something else he might give her, much to the amusement of the other girls. After about the sixth interview the therapist had to point out to her that it was difficult for him and the others to participate if she were going to do all the talking and acting out and emphasized the group relationship. She resented this, sulked a little, indicated she would not come back. She missed the next appointment but then came again and followed through though not quite so out of hand as previously. After the interview she revealed privately to the therapist that she only talked about sex so much in order to keep up with the others and that actually she had not been sexually promiscuous. When dilatin was used for suppressive therapy she did quiet down. (To her unconscious it probably meant a gift and special attention from the therapist.) But then later she revealed that she usually had not taken the capsules after saying they had helped. Finally it was decided to treat her individually.

For the first individual session she was silly, disorganized in her thinking, impulsive, circumstantial, spoke under pressure of speech and demonstrated flight of ideas. She said she "felt like three different people, sometimes younger, sometimes older and sometimes like herself." There was little evidence of adequate ego and she gave the impression of psychotic thinking, manic in type. She verbalized hostility freely. In the next session she verbalized a great deal of aggression toward the personnel at the school. She asked many questions but then quickly answered them herself. Suddenly—"Tell me the truth Dr. Baum, am I off the bean?" She came in with her body marked up with razor blade scratches and cuts at the third session. She wanted to know what made her do such things. Her extreme need for love, and attention were pointed out, as well as the desire for approval of the group which made her very suggestible and exhibitionistic. The sado-masochism was not discussed. Throughout the interviews this therapist emphasized again and again his confidence in her, identified with her freely, but at the same time whenever reality could be pointed out to her this was done.

In the fifth interview she described herself as "nuts." She wants to have a "father who would smack her and teach her the right things." (need for punishment — reaction to permissiveness of therapist)

Also "sex was to be used." "What's my old man yelling about. He's made four (kids) and I haven't made any yet." "I will give them till January (to get me out) or they can kiss my rear." She resented their trying to play momma and poppa to her. "He's nothing but a kid himself." "I'm happy on one side and sad on the other." (Often J. B. laughs inappropriately) Hostility was freely verbalized but as yet affect was shallow and displaced. "I think I need an operation cause I know I'm nuts. I need to be in a room by myself."

During the following hour, J. B.'s seductive behavior was discussed as well as her phantasy that all men could me "made." Now as often, she expressed her distaste for those "queers." ("girls who put their arms around you or are around when you are undressing.") Her own homosexual impulses were not discussed.

Two interviews later — "I don't fart around . . . when I go home I go where I want and I get what I want." Sibling rivalry was expressed against "those snots up there who have been there less time than I have and have jobs." She was very disturbed during this hour and indicated she must be nuts because she bends forks and breaks glasses. She wanted to be sent to Farnhurst or Gov. Bacon Health Center. (Other girls in treatment actually did think that J. B. was "nuts" because of her overtly disorganized behavior.)

The note in the ninth interview reveals that she is still trying to impress the therapist that she was crazy and that she "had bad in her, was a kleptomaniac and was sex crazy." After all, "they all tell me I am crazy and talk about me." (It was the therapist's impression that because of the individual attention and understanding that she was getting that

anxiety and guilt were being mobilized. The desire for transfer to a psychiatric facility was probably a positive transference reaction as well as masochistic.)

During the tenth hour she was encouraged to talk about her family. She said she "was sex crazy and that her sisters were crazy and sluts. My mother and father are crazy. They are pigs." (When first asked about them she said they were dead). With regard to what she is learning at Woodshaven she said defiantly "anyone can be good if they want to and anyone can be bad if they want to, but I am not going to be good for them." (re Woodshaven)

Now, as frequently, the therapist discussed with her the significance of love and understanding in childhood for the development of security.

During the following hour she described how she often squealed on her mother (with obvious glee) when the former ran around with soldiers, and how her father beat her mother up. "I spit in her face." "He paid me for telling on her." Hate for the mother was freely verbalized. J. B. felt the mother had rejected her. She always turned to her father. In addition J. B. asserted that she provided women for her father. "I told you I was crazy, Dr. Baum. I am just plain ignorant." In the next few hours she continued in the same vein. She described her father as younger and better looking than the mother. J. B. often went out with him, including moonlight rides with dancing on boat trips. Often other boys tried to make her and the father had to "protect her." She voluntarily denied that her father had tried any "dirty stuff." He was often mistaken for J. B.'s boy-friend. She laughed with pleasure in describing the hostility of her father for his wife. But at the same time said she often caught them having sexual intercourse. (The above clearly illustrated the Oedipal phantasies.)

On the 14th individual visit, J. B. was actually depressed. This was the first time that she showed an appropriate affective reaction. She was not even wearing any makeup, which was most unusual for her. When the examiner greeted her, there was no response. She was lacrimose and verbalized hostility freely against everyone at Woodshaven and particularly against her family. She called them every name she could think of in the best appropriate slang. They were "whores, no good." Her father was once in the newspapers because of a fight. She wishes that he had died. They had promised to come to see her on Sunday but did not appear. She was waiting and sat waiting all day. She hated them for this. They also promised to send some clothes but didn't. She used to steal because "they would not give me clothes." Since they still were not giving her clothes she "would steal again." J. B. stated she was crazy and if they didn't believe it, she was going to show them. She wished that she were dead. Although there was still disorganization in her thinking the significant thing was that affect and ideation were closely juxtaposed. J. B. was asking for love and faced her feelings instead of suppressing and displacing them. Anxiety, insecurity, need for love and frustration with resultant hostility and guilt were being faced. The reality of the home situation was more clearly in focus for her. (The therapist was sufficiently concerned about the intensity of the reaction to contact the superintendent of the school to keep J. B. under observation. Possible transfer to a psychiatric facility was considered.)

At the next interview J. B. was calmer than at any other time. But when the therapist attempted to point out the gains made she felt impelled again to prove how "nutty" she was, but it was half-hearted. Confidence in J. B. was reemphasized. She was able to discuss her needs for affection and attention.

During the next hour she was exhibitionistic, hostile and had the "don't give a dam" attitude. Hostility was verbalized to therapist but only with encouragement. "Don't worry about no one but myself. They can all go to hell."

Next hour she continued her "don't give a damn, they can kiss it attitude." Again her need for affection and understanding was underlined and it was pointed out that acting out hostility would bring hostility in return. Meanwhile the school indicated that J. B. was much improved.

During the 18th hour J. B. spoke in a more mature, organized way than at any time since

coming to the clinic. She showed fair insight into her various problems. She appeared to have developed enough integration of ego and superego so that she could stop and think after her initial impulsive reactions. Her gains were again pointed out. She, for the first time, emphasized the therapist's understanding attitude.

In the next hour she continued to relate well to the therapist and continued her improvement at the school. She verbalized hostile feelings against family's lack of interest but in a more realistic manner, though still ambivalent.

She gauged her improvement in the eyes of others by describing how now when she walks by the boys in the neighborhood in a dignified manner they do not call her tramp anymore. Or if anyone does, the others defend her. She was obviously pleased with this. (improved self esteem)

In the following hour I had an opportunity to talk with J. B.'s father. He was still with A. A. at that time. Mr. B. revealed considerable anxiety and guilt about his relationship with this daughter especially with regard to his drinking and neglect of her. He confirmed the fact that the mother and oldest daughter reject J. B. He indicated that the present home environment was unsuitable.

The last two hours were spent reviewing realistically the home situation, her gains in treatment and at school, and plans for future as well as termination of treatment at the clinic.

She voluntarily raised some questions about her younger sister who was behaving the way she used to and wondered if she could also be treated.

It was recommended to the school that J. B. be considered for partial parole.

A follow up recently, 6 months later, revealed that J. B. had been working for some time on a full time, living-in job which included care of children. She was on complete parole. She has been getting along very nicely and is making a satisfactory adjustment. Seductive, exhibitionistic behavior toward boys still exists but apparently is adequately controlled. Meanwhile the father has dropped out of A. A. and is alcoholic again, and the younger sister is at Woodshaven and in treatment with another therapist.

The dynamics in this case have only been touched on as the problem was presented primarily to demonstrate an approach to treatment.

The fine supervision by the staff of Woodshaven School for Girls and their cooperation with this therapist facilitated the positive result in this girl's treatment.

A NOTE ON THE PROBLEM CHILD

WILLIAM S. ROBBINS, M. D., *
Farnhurst, Del.

A problem constantly before the attention of the general practitioner is, "what to do with the disobedient, destructive, defiant, wilful or non-conforming child?" The boy or girl who fails to achieve the degree of conformance or attainment required by the parent — whether or not they are aware of this demand — is a continuing source of disappointment to the parent. This nidus of disappointment, like an acute inflammatory process, spreads in all directions and sets in motion a continuing cycle of events that lead to mounting anger and tension in both parent and child, to the imposition of many restrictions, the use of all available forms of punishment, recourse to the authority of the courts, but finally — and most often — to the office of the trusted family physician for his help.

The source of this struggle between parent and child is to be found in the parental attitudes toward life and their effect on the interpersonal (child-parent) relationship. Understanding of these dynamisms, as in all disease processes, is a prerequisite of rational therapy and this understanding will reveal why punishment and privation so often fail to produce the desired result.

D. S., a five-year-old boy, was referred to the Mental Hygiene Clinic by a nearby agency. Mrs. S., the mother, had approached this agency for help because she was having so much difficulty managing the boy. As she described him, he was in complete rebellion against her. She was unable to tell him anything or to control him in any way; he was unresponsive to every type of discipline and

*Part-time Psychiatrist, Mental Hygiene Clinic, Delaware State Hospital.

privation imposed, resentful of restriction and reacting with increasing stubbornness and anger. There appeared to be nothing in this child that pleased the mother at the time the problem was presented in the Clinic.

An examination of this boy revealed that he was a healthy, calm, really self-confident youngster of superior intellectual ability. Exploration of the family and school situation brought to light the fact that the boy was making a good adjustment in every area — except in relation to the mother. Attention was then directed to Mrs. S.

Mrs. S. was seen twice for short periods of time. These two visits were almost a month apart. The first session was devoted to allowing free expression of the problem. She was encouraged to paint the picture exactly as she saw it both at this moment and as she felt it had developed in the past five years. The discussion gradually was turned toward Mrs. S's own present life and background and it became apparent that she was a very anxious, unhappy woman. Mrs. S. had come from a home in which she always occupied a subordinate position, in which she was restricted and guided in every sense of the word, and had approached her adulthood, marriage and parenthood without ever having had an opportunity to exercise independent judgment or to assume full responsibility for the consequences. This background, in her case, was conducive to the development of an extremely selfish attitude toward life wherein one's needs either were satisfied immediately or anxiety ensued in conjunction with hostility toward the frustrating individual.

This attitude, which made the necessary material sacrifices seem so burdensome, appeared to be the crux of the problem. The idea was presented to Mrs. S. for consideration as a possibility, it being much easier for Mrs. S. to tolerate this estimate of her attitudes in this fashion rather than to confront her with it as a fact. The latter method would have made her feel as if she were being criticized. A discussion of this resulted in the mother's realization that what she was responding to and becoming hostile about was not the child, himself, but the fact that his being in the world and his care made it necessary for her to forego, on a more or less temporary basis, the satisfaction of her own needs. The more he resisted her, the more time it was necessary for her to spend with him and the net result was a state of increasing anger. The child was reacting not to her demands, per se, but to the attitude which attended them. He met hostility with hostility and threats with defiance.

An interpretation to the mother of these motivations and responses in herself, brought an immediate improvement in the relationship between mother and son. Now she could see him as an individual — as a boy — as her son — not as something that stood in the way of her own satisfactions.

This relationship and the psychology of the personalities involved is far more complex than is indicated in the foregoing. However, this case does serve as an example of the interplay of forces in the relationship of a mother to her children, and, that at times, the relationship can be improved by a fairly direct therapeutic approach. This is possible only where the mother is in a receptive state of mind, actively seeking help and where the dynamic situation is thoroughly appreciated.

TWO CASES OF JUVENILE SCHIZOPHRENIA

TATJANA THALLER CANKI, M. D.,*
Farnhurst, Del.

Since 1908, when Sante De Sanctis introduced a concept of dementia praecocissina to differentiate the forms of schizophrenia occurring early in childhood, the problem has been largely discussed and many cases reported. Two cases observed in the Delaware State Hospital, studied for years and treated with all methods at our disposal are reported.

Case 1. Mary Frances V., fourteen years of age, was admitted to the Delaware State Hospital on November 1, 1947. The family history is negative for nervous or mental illnesses, maladjustment or feeble-mindedness. Patient was the second of three siblings. Her birth was normal, and she started to talk at the "normal age," and started to walk at twenty months. Nocturnal enuresis continued until the age of nine years. She had always been a difficult baby and child; was moody, without sense of responsibility, and especial-

*Junior Assistant Physician, Delaware State Hospital.

ly jealous of her older sister. She never played with other children or with dolls and other toys. Most of her play consisted of "make-believe." She never seemed to be a happy child. Patient had the usual childhood diseases.

Patient has always been a difficult child, but her parents did not realize that she was sick until the age of six when she started school. There she could not learn as other children did, and seemed fearful and apprehensive of her environment. She talked to herself for many years and pretended to be various people, particularly movie stars. She has shown no noticeable preference for either parent.

Because of her difficulty in school, she was referred to the Mental Hygiene Clinic in October of 1941, when seven years of age. On the psychological test she was considered to be of dull average intelligence with a rather severe mental dysfunctioning, emotionally disturbed and fearful of failure. For seven months she was given individual psychotherapy at the Mental Hygiene Clinic.

Since that time she has been placed in special schools for problem children, and has also been seen regularly by a psychiatrist. However, her progress in learning has been poor. She manifested difficulty in adjusting, and displayed nervous habits such as pulling her hair and talking to herself. With many ups and downs, the next six years passed. At the age of nine or ten, she began masturbating. Her menses were established at twelve years of age.

In September of 1948, she became more upset than usual; became mute, refused to eat and would not put on her clothes. This determined her hospitalization. When seen in the hospital, she manifested manneristic behavior, repetitive conversation; and stated that she heard voices for a long time. These voices accused her of being wicked, and showed evidence of being jealous of her because she had stones in her hair and also stones in her back. She appeared very fearful and apprehensive, but attempted to answer all questions.

On physical examination, she appeared to be of asthenic habitus. Examination was negative. Laboratory findings including urinalysis, count of blood cells, blood chemistry and serology, spinal fluid analysis were within normal limits. X-ray of chest and the skull was negative. A diagnosis of schizophrenia, catatonic type was made.

Electro-shock treatment was given without improvement except that she did begin to eat. She became more uninhibited in her behavior. She remained hallucinated and delusional, manneristic and autistic. She had periods of agitation, destructiveness, aggressiveness and impulsiveness which were only temporarily controlled by electro-shock treatments. From January to April of 1951 deep-coma insulin was given with some improvement in her behavior.

She is now 17½ years of age. She is institutionalized. She is very psychotic and her prognosis is poor. She has had psychotherapy since seven years of age, had special educational attention and later had electro-shock treatments and deep-coma insulin treatments.

Case 2. Nat E. was committed to the Delaware State Hospital on December 18, 1947, when he was twelve years of age. Family history is negative for mental or nervous diseases, mental deficiency or alcoholism.

Patient was the only child. Birth was normal and early development seemed entirely normal except for the fact that from the beginning he was a restless sleeper, and as a baby he banged his head against the wall or the side of his crib until he was eighteen months or two years of age. He used to get up on his hands and knees in his crib and rock back and forth; he broke two iron cribs before he outgrew them. At the age of three, he outgrew this habit. When he was five years of age, he became a special behavior problem because of continuous restlessness and nervousness. He had temper tantrums, yelled and cried, and had frequent nightmares. He would not sleep, but would walk around his room talking to himself, or would tear up the bed sheets or break the furniture. Because of this behavior, he was placed in special schools for problem children from the very beginning. In 1946, when he was eleven, his I. Q. on Binet classification was 80; dull normal group. The school physician reported the following: "Rorschach shows definitely a warped personality with marked psychotic

trends. He is exceedingly nervous, irritable and it is impossible to keep him in the classroom. He shows slow but steady deterioration, with marked evidence of psychosis. Apparently he is suffering at times from auditory hallucinations. He is greatly over-stimulated, showing aimless activity." At that time, he was considered by the same physician as a high-grade to borderline type of mental defective with psychosis, probably due to abnormal intra-cranial pressure.

He has been examined at the Mental Hygiene Clinic where on repeated tests, he was found to be of high average native endowment. His perceptions of reality were obscured, and his physical proficiency reduced.

Nat spent another year in the special school, and in December of 1947, when twelve years and three months of age, he was committed to the Delaware State Hospital because of hallucinations and irritability. Patient is violent at times destructive in regard to clothing and furniture.

Physical examination showed him to be of asthenic habitus, fairly well developed and fairly well nourished. Examination was negative and no abnormal neurological signs or symptoms were noted. Eyegrounds were normal. Laboratory data including urinalysis, count of blood cells, Hgb, blood urea nitrogen and sugar, blood serology and spinal fluid analysis were all within normal limits. X-ray of chest and skull was negative.

On mental examination the examining physician had the following impression: This is a highly intelligent boy who shows marked anxiety tension and restlessness, but who is quite capable of controlling himself. He seems to be abnormally pre-occupied with himself, and there is evidence of lack of social adaptability. One may call his present state of mind an anxiety state but one has to keep in mind that some of his peculiarities are suggestive of a schizoid personality. He was correctly oriented.

A few days after the mental examination he became restless, demanding, broke window panes, became combative and used obscene language, and after a few days of observation, he was considered psychotic. Since then he has alternated periods of relative improvement when he is easy to manage and periods when he is acutely disturbed and violent. His good periods never lasted longer than three weeks, and then he showed pre-occupation with certain stereotypical ideas, asking the same questions ten to twenty times during one interview, and interjecting them suddenly without adequate reason. His interests were studying mathematics, reading vocabulary or crocheting.

His restlessness was treated with sedation. Dilantin proved ineffective. A special teacher was appointed who came regularly to spend a few hours with the patient. His interest remained superficial, and he did not seem to benefit. Special attention was given by the personnel to this patient. He was anxious to receive it but he did not develop attachment to others. Because of his severe hyperkinetic spell, he was given a number of electric-shock treatments. Benefit was extremely limited, and it was not worthwhile to continue the treatment. Psychotherapy was of no avail.

From April to June of 1950, deep-coma insulin was given. He improved only temporarily in his behavior. He had auditory hallucinations.

In December of 1950 he had four convulsive treatments at the University of Pennsylvania, produced by oxygen inhalation in the pressure chamber. He remained one of the most difficult management problems in the hospital and, not too long ago, he swallowed a dozen hooks and springs which he had removed from his bed.

In April of 1951 transorbital leucotomy was performed. Three months later he is still manageable on the ward. He remains hallucinated in auditory sphere and unable to concentrate.

While there has been some doubt as to the presence of undefinable organic factors, it is the concensus of opinion of the staff members that this patient suffers from a malignant type of juvenile schizophrenia. There has never been any evidence of encephalitis or other brain diseases, and there has been no spontaneous seizures. The electroencephalogram shows "an altered cortical excitability" but not characteristic of any specific brain disturbance.

THE NECESSITY OF INDIVIDUALIZATION IN INSULIN-COMA THERAPY

N. T. ARIKIAN, M. D.,*
Farnhurst, Del.

Since Dr. Manfred Sakel's discovery of insulin-coma therapy for schizophrenia and other mental diseases this treatment is of global importance in the practice of psychiatry, and it has appeared in medical literature in thousands of articles, papers, magazines and text books in every country on earth and in many different languages. This contribution to medical science has aroused many problems, some solved — some not solved.

The intention of this article is to cause an interest in medical circles of this problem of individualization in insulin-coma therapy.

In the course of insulin-coma therapy, the patient under treatment passes through a long procedure of different reactions and different levels of coma until the deepest level of coma is reached. Authors have divided this procedure into as many as five different stages.

The necessity of individualization in insulin-coma treatment resulted from the fact that the same patient each day was awakened at a different level of coma and then exhibited a different mood and behavior commensurate with the depth and duration of coma from which he was awakened on that day.

The following examples, a few from many, will prove this fact:

A female patient with the diagnosis of schizophrenia, simple type, with the following symptoms: lack of interest in work which she liked before the onset of her mental illness, lack of ambition to do anything, introverted, could not face situations in every-day life, retreated into the realm of fantasy, was indifferent to environment, unwilling to return to the world of reality, etcetera. When this patient was awakened at the end of the second stage of insulin-coma, she displayed interest in environment and ambition to do various types of work. She was not as much retreated into the realm of fantasy, and began to come back to reality. However, when she was awakened at the end of the fourth or fifth stage of coma, she was depressed, introverted, and irritable, thus showing changes not favorable to her mental health.

Another patient diagnosed as paranoid condition had the following symptoms: He stated that he was constantly followed by people who spied upon everything he did, and that particular people were against him and were threatening to poison his food. He changed jobs frequently because he felt that people were hostile toward him. During his insulin-coma therapy, this patient was first awakened at the end of the second stage of coma, and then he exhibited more pronounced paranoid symptoms than before treatment. Following this the patient was taken to the fifth or deepest stage of coma, and when awakened here he showed a lessening of his paranoid ideas and trends. He started to socialize, become more reasonable, and consequently showed a marked improvement over all. This patient showed improvement only when his insulin-coma was terminated in the deepest stage, in contrast to the previous case which showed the most improvement by being awakened at the end of the second stage of coma.

Another patient with autistic and catatonic symptoms, awakened at the end of the second stage of insulin-coma, exhibited better contact with reality, and conversed well. His emotions were stimulated and his previous picture of rigidity and inactivity was modified to one of jovial co-operation. When this same patient was awakened at the end of the fifth stage of insulin-coma, he showed no contact with reality, was mute, withdrawn and depressed. When awakened again in the second stage of the coma on subsequent days, the patient again showed contact with reality, conversed well, etcetera. Continued awakening daily at the end of the second stage resulted in almost manic behavior reaction. Therefore, to obtain a more normal emotional balance, the patient was not awakened until the end of the fourth or fifth stage of coma during the remaining treatments. Through this procedure the patient was directed to a satisfactory behavior pattern by the insulin-coma therapist.

It should be well understood that in insulin-coma therapy, each of the individual patients, although they may be in the same diagnostic category, must be considered separately as an

*Resident, Delaware State Hospital.

individual, and treated according to the specific requirements of his mental condition, which are individually variable. Statistical reports about the insulin-coma therapy give different percentages of results. Among the reasons may be the lack of individual application of the insulin-coma therapy.

SUMMARY

1. There exists a relationship between the mental changes of the patient under treatment and the duration and depth of the insulin-coma in which the awakening from the coma occurs each day.

2. Patient's mental condition is directed and regulated by the different depths and duration of the insulin-coma.

3. For this reason, the insulin-coma therapist has to find out the optimum of the depth and duration of the coma peculiar to the individual by thorough observation of the patient's reactions during each treatment in order to determine the most favorable depth and duration of coma for the following day of treatment.

4. Since there are great differences in the reaction of the patients, it is necessary for the therapist to observe closely and evaluate each patient's reactions to the treatment. Therefore, a therapist who has the knowledge and experience with individual insulin-coma treatment will be successful in obtaining the best results.

AN IDIOT-SAVANT?

JOSEPH JASTAK, Ph.D.,*
Farnhurst, Del.

Carl was referred to the Mental Hygiene Clinic at the age of 11 with the parental request that he be committed to the Colony for the Feebleminded. He had previously, at the age of 4, been diagnosed as feebleminded in another clinic. As a result, he had spent several years in private schools and in a State Training School for mentally retarded children.

At seven, he had been examined at the Delaware Mental Hygiene Clinic. His Stanford-Binet I. Q. was 67, but the psychologist concluded that the boy was emotionally disturbed and not intellectually deficient. At this particular interview his behavior was thoroughly unpredictable. He was overstimulated to the point of violence. He ran from door to door, turning the knobs and keys, shutting and opening the doors, and touching the various pieces of furniture in the room, without any apparent reason. He had few social inhibitions. He would turn to people for the immediate satisfaction of his irresistible impulses. Otherwise, he disregarded their pleas or presence in favor of aimless rushing.

His language abilities were found to be extremely defective. The intelligence test gave highly variable results — some exceptionally high, most of them very low.

When Carl was examined again at the age of 11, he had grown in physical dimensions and sedateness. However, some degree of dissipation and spontaneity were still observable. Erratic ideation had partly replaced erratic behavior. Unimportant and fanciful associations were in evidence as he tried to answer questions. He was unusually imaginative and stereotyped at the same time.

His speech was still poorly articulated, but fairly intelligible as a result of many years of diligent speech therapy. He accurately reproduced some unusual bits of knowledge, but the majority of his responses were either wild guesses or irrelevant free associations. According to him, "Taro" was the capital of Japan, "soldiers" invented the airplane, "Dolores" wrote Hamlet, and "George Washington" discovered the North Pole.

On reasoning tests, he used the same meaningless phrases to explain many unrelated problems. Superficially, he had improved since the age of 7. He was now quieter, more willing to conform, and better able to concentrate on assigned work. At school, he had learned in reading and spelling as much as is expected from boys of average intelligence. His achievement in arithmetic was superior. His intellectual endowment was considered to be at least high average, but he was thought to be suffering from a mental condition which beclouded his reality perceptions and interfered with normal motor functions, including those of expressive language.

Carl was admitted to the State Hospital at the age of 13 because of persistent destructive

*Chief Psychologist, Delaware State Hospital and Mental Hygiene Clinic.

tendencies, uncontrollable nightmares, and episodic assaults upon his parents. His personal history records a very early onset of overactive and combative behavior. Due to the great violence of his outbursts he never attended public school. Though unusually intelligent in some respects, he could not dependably concentrate on his lessons or adjust to ordinary social amenities.

Since admission to the hospital he has been subject to unmitigated, compulsive behavior. If frustrated, he becomes dangerously explosive. He has had electroshock, insulin coma, convulsive treatments produced by oxygen inhalation, and leucotomy. He has not responded to any of these treatments. He presents one of the most difficult management problems in the hospital. He is bothered by delusions and hallucinations. Some time ago, he has swallowed a dozen hooks and bedsprings which had to be removed from his stomach by surgery.

In arriving at a psychiatric diagnosis organic problems were given due consideration, as the electro-encephalogram showed "abnormal high voltage slow waves of 3, 4, and 5 per second with occasional spike formations found generalized throughout both hemispheres." These grossly abnormal tracings "are indicative of an altered cortical irritability." The consensus of staff opinion was that this boy suffered from a malignant type of juvenile schizophrenia.

Carl is now 16 years old. During the past three years he has had three psychological examinations consisting of aptitude tests and the Rorschach. The results were in all three instances strikingly similar. The aptitude pattern is recorded in the circular graph of Figure 1.

There were no significant changes in the psychometric results following insulin shock or leucotomy. Carl is still the bright boy who acts like a moron. Changes in the contents of his behavior and thinking have undoubtedly occurred with age, but the structural forms of to-day are uncannily similar to those displayed at the age of 11 or 7 or 4. He has had intensive psychotherapy while away at school. Neither psychological treatment nor strictly medical attention have had the desired results.

The psychometric graph portrays Carl's strangely disparate abilities which are closely tied up with his chronically abnormal personality structure.

FIGURE 1

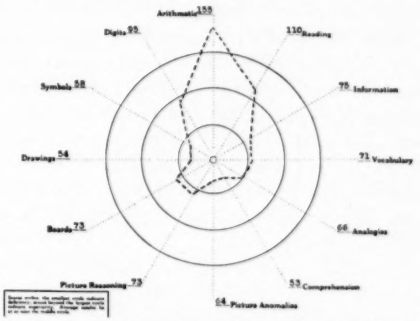

Fig. 1. Graph showing the distribution of abilities of the patient discussed in this paper. Arithmetic is very superior. The related abilities of reading and digit span are average. All other abilities are either inferior or defective.

Five of the measured abilities are very defective, four others are inferior, and three are average or superior. Carl's mathematical abilities are extraordinary. He has good motivational assets which, because of extreme, multiple character deficits, can be exploited only in the interest of compulsive, protective, and self-destructive mechanisms. The I. Q.'s of most idiot-savants rate them feebleminded. The idiot-savant is known as a person who excels in one ability and is defective in most other abilities.

Each State Colony has its maladjusted geniuses who perform mental acrobatics or acts of manual skill far beyond the capacity of average mortals. Despite their breath-taking achievements, or perhaps because of them, they are unable to meet the simplest realities of daily living. The peak of excellence is often in the mathematical area, but it need not be there. Exaggerated aptitudes may occur in any one of the abilities listed in the graph. Persons with downward peaks, diametrically opposite to the one here illustrated, are not uncommon.

Abilities thus distributed are nearly always a symptom of severe and chronic personality disturbances which are refractory to known methods of therapy. The parents of such children report the presence of mental and

physical debilities from birth on. The disorders become aggravated in the course of development and training partly because neither parents nor experts know what the proper methods of treatment are or what the education of such children should be.

The so-called idiot-savant is practically never feebleminded. He is merely an extreme case of the variable personality patterns which characterize all human beings. He is afflicted with multiple deficits of unknown origin. The deficits are suggestive of both organic and functional illnesses. That the two may co-exist in the same individual is not always fully appreciated. The disorder which is observed last and which is superficially the most conspicuous is given diagnostic preference, even though the basic and original trouble lies far deeper than the side-effects seem to indicate.

A great deal of research, both physiological and psychological, will have to be done before we know how these "other-worldly" individuals come to be and how, if at all, they can be treated and trained to use their extraordinary potentialities for high-level cerebration which they seem to possess.

One fact seems to stand out above all else. They are not idiots, not even morons. They only act as if they were feebleminded because they are very, very ill from the very, very beginning of their unfortunate lives.

PSYCHOLOGICAL STUDY OF CHILDHOOD SCHIZOPHRENIA

A Case Report

W. H. TRACY,*
Delaware City, Del.

The incidence of childhood schizophrenia is still an unsettled question. It is considered to be extremely rare by some authorities. Others seem to feel that it occurs more commonly than is generally recognized. In any case, it appears that until fairly recently many children who are basically schizophrenic have not been recognized as such, but have been considered as suffering from various other conditions ranging from "feeblemindedness" through "epilepsy." Kanner has delineated early infantile autism as essentially a schizophrenic condition.[1] This represents a first step in clarifying the childhood schizophrenic syndrome. Other cases of pseudo-feeblemindedness may too eventally be recognized as suffering from a schizophrenic emotional withdrawal.[2] The case to be presented in this short paper represents a patient who upon gross inspection appeared to be feebleminded. As a matter of fact, this patient was so emotionally disturbed that she actually was functioning, in general, on a mentally defective level. However, her low level functioning was not due to innate lack of intellectual equipment, but to severe psychotic disorder which had disrupted her intellectual, as well as her emotional life. The endeavor of the brief report to follow is to present data as to how phychological study contributed to the understanding of the schizophrenic maladjustment in this particular case. Also a few notes are offered as to the responsiveness of the patient to psychotherapy up to the present time.

The clinical picture of symptomatology differs between children and adults in schizophrenia.[3] As is to be expected, the older the child the more the symptoms will resemble those of the typical adult schizophrenic. With the child delusional material and symbolization are relatively more simple and naive than with the adult. Kanner presents Potter's list of reactions which are applicable to childhood schizophrenia. They are as follows: "1. A generalized retraction of interests from the environment. 2. Dereistic thinking, feeling, and acting. 3. Disturbances of thought manifested through blocking, symbolization, condensation, perseveration, incoherence and diminution, sometimes to the extent of mutism. 4. Defect in emotional rapport. 5. Diminution, rigidity and distortion of affect. 6. Alterations of behavior with either an increase of motility, leading to incessant activity, or a diminution of motility leading to complete immobility or bizarre behavior with a tendency to perseveration or stereotypy." [4] Kanner also notes that children cannot be divided into schizophrenic "types" as are adult patients. Some children deteriorate, in others catatonic

*Acting Chief Psychologist, Governor Bacon Health Center.

[1] L. Kanner, Child Psychiatry, pp. 716-720.
[2] L. Kanner, A Miniature Textbook of Feeblemindedness, pp. 10-11.
3 L. Kanner, Child Psychiatry, pp. 710-712
4 ibid. page 711

features are frequently manifest, hebrephrenic fragmentations are found in some. Paranoid delusions, if found, are not systematized or fixed.[5] Lack of as clearcut schizophrenic signs in children as in adults makes the problem of diagnosis more difficult. With a less clearly defined constellation of signs difficulty is encountered in differentiating childhood schizophrenia from other clinical syndromes. Schizophrenia in childhood is probably most often misidentified with either, or both, of two conditions. These are, first, inherent, or real, feeblemindedness, and secondly, psychosis apparently resulting from organic deficit. In formulating diagnosis with our diversified patient population here at the Health Center we have found the necessity of combined, cooperative effort between the medical, psychiatric, social service, and psychological divisions.

CLINICAL DESCRIPTION

The patient to be discussed in this paper is a twelve year old female. Matilda has been in residence at the Center for about ten months. She was admitted to the seizure ward because her mother's complaint that she was unable to keep up with her school work and that she had had "convulsions" prior to admission. No seizures have been observed during her stay here. Her ward behavior from the beginning has been unusual. In summary, ward observers considered her to be either feebleminded or psychotic, possibly both. No significant physical defects were discovered by the examining physician and the consultant neurologist. Psychological examination was requested by the psychiatrist in charge of the ward. The differential problem was one of ascertaining whether the patient was inherently mentally deficient with psychosis; brain damaged and psychotic; or suffering from childhood schizophrenia.

PSYCHOLOGICAL STUDY

As is our usual procedure, the patient was first administered our basic intelligence scale. The scale used was the Wechsler Intelligence Scale for Children. The Jastak Wide Range Achievement test was administered to ascertain level of achievement in basic school subjects. Study of the various quotients derived from the intelligence scale, and test behavior, indicated the need for further testing. The Rorshach ink blot test, the Bender-Gestalt Visual Motor test, the Strauss-Lehtinen marble board test, and drawings were therefore added to the battery. The reason for the inclusion of these particular tests should be revealed by the nature of the material obtained from each. [6] The results of the psychological study are presented in summary form: As far as "global," or overall, intelligence is concerned, the patient was functioning at a defective level in both verbal and performance areas. Her native capacity, or intellectual potentiality, appeared to be at least average, however.[7] Extreme subtest and factor "scatter" suggested severe personality disorganization. The patient was able to understand instructions and follow them through only in those instances where she felt so inclined. In other words, volitional effort was regulated by her attitudinal state of the moment. Her verbal responses requiring comprehension and judgement were not thought through logically and were highly autistically colored. Her achievement in school subjects was in general at the third grade level. The Rorshach test findings were characterized by perseveration, quick reaction time with little expenditure of energy, and inadequate form level. Her weak reality contact was well indicated on this test. The patient's Bender-Gestalt drawings, and drawings of a person, were primitive and suggestive of either emotional fixation or regression. On the one Strauss-Lehtinen marble board presented to the patient the pattern was copied reasonably well.

The subject's response to this test was not what one would expect from a brain damaged child. Reversal of the colors utilized on this test corresponded to a similar tendency toward reversal of colors on the block design test of the intelligence scale. Most likely this is another sign of schizophrenic negativsm. The patient's behavior during the examination was characterized by a fixed repetitive expression, a silly esoteric smile, grotesque moments, and bizarre verbalizations.

In summary, the examiner's impression on the basis of the psychological examination was

5 ibid.

6 A specific basic reference for each test used in this study is included in the bibliography.

7 Joseph Jastak: "A Rigorous Criterion of Feebleminded-ness," J. Abn. Soc. Phychol. 44, 1949, pp. 367-379.

that the patient was not inherently feebleminded, but that her global defective functioning was a consequence of psychotic disturbance. Nor did the psychological picture presented appear to be the typical "organic" one by any means. It is believed that the personality picture presented by this patient represents either emotional fixation at an early stage of development or extreme regression. In either case the psychopathology appears to be essentially schizophrenic with marked autism.

In the presentation of this case to the staff for diagnosis the psychological findings were added to those obtained from the psychiatric and neurological (including an electroencephalogram) examinations, and the social history. The staff diagnosis was schizophrenia, thus corroborating the psychologic findings.

PRESENT STATUS

Matilda was assigned to a psychotherapist.* He has been seeing her regularly for approximately six months. For the first four months she was seen once a week. Since then interviews have been increased to a twice a week basis. In all she has had to date approximately thirty hours of psychotherapy. On the basis of her ward behavior, classroom adjustment (she has recently been placed in a special class), and her family's judgement, Matilda has shown decided improvement.

Her psychotherapist shares this opinion, but believes that most of her improvement to date is still of a superficial nature. [8] Change in surface behavior and loss of symptoms has been quite dramatic. In his opinion her improvement is due to overall excellent care and sympathetic understanding received in the ward and special classes, as well as participation in individual psychotherapy. More intensive and continued psychotherapy for some time are necessary before Matilda will be ready to adjust adequately at home and be able to regain lost ground in school.

The writer has attempted to make, in summary form, two points. One is the importance of recognizing childhood schizophrenia in diagnosis, and two, the possibility of producing improvement in this type of case. Whether relatively complete adjustment is possible for Matilda remains to be seen.

*All psychotherapists are under the supervision of the Child Psychiatrist, Dr. Calvin Settlage.

8 Due to limitation of space, the dynamics brought to the surface in psychotherapy, techniques used by the therapist, and changes in the patient's behavior cannot be presented in this paper.

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A CHALLENGE TO YOU, THE REFERRING DOCTOR

MARJORIE HUBBARD,* A.B., M.S.S.,
Farnhurst, Del.

How can you help your patient most when you refer him to the Mental Hygiene Clinic? Patients bring out some of the answers to this question both when they have been referred by doctors who have wisely counselled them through the experience and by those doctors who have not fully understood the clinic. After your patient leaves your office he continue to think; fear, anxiety and tension mount. Much of this could be avoided if in the first interview you anticipate some of the anxiety. Questions such as the following are important to your patient;—"Do you think I'm crazy?" "Isn't the clinic at the Delaware State Hospital?" "Will they commit me to the State Hospital?" "How are appointments made?" "How long will I wait for an appointment?" "What will happen to me at the clinic?" "Do I have to go?" "What happens after the diagnostic interview?" If it is a parent seeking help with a child the questions go further — "What will they do to my child?" "Will I know what they think is the matter with him?" "Do you think I'm a terrible mother when you suggest sending my child to the Mental Hygiene Clinic?"

The referring physician can be of invaluable help to the patient in accepting referral to Mental Hygiene Clinic if the time and pa-

*Chief Psychiatric Social Worker, Mental Hygiene Clinic, Delaware State Hospital.

tience have been taken to foresee the pitfalls that are the result of quick referrals. The clinic is only as strong as the referrals it receives and often times patients are lost through inadequate explanation. Since the referring physician knows the patient and already has his trust, he has the best opportunity to make the referral a success. He also knows when the patient needs the clinic and is ready to be referred. Generally speaking the referring physicians have made a valuable contribution to our service by the orientation they have given their patients who are coming out to Mental Hygiene Clinic. We, the staff of the clinic, also appreciate the care taken in selecting patients who can benefit by this service. Perhaps the remainder of this paper may help to further clarify some of the questions which we find patients have most frequently asked.

"Do you think I'm crazy?" Many patients wonder this even if they do not express it. To anticipate this takes away much of the patient's fear. He has no doubt spoken of being nervous, upset, disturbed, anxious, unable to keep friends or hold a job. These phrases of the patient can be used to assist him in understanding how the clinic may help him with whatever is disturbing him and at the same time give him the reason for the referral on a basis he can accept rather than on a feeling he is crazy. The same applies to a parent distressed over his child's behavior—whether it is aggressive, withdrawn, indifferent, defiant, malicious or anti-social. Again, in order for the doctor to have recommended the clinic the parent has probably described his child's behavior and, if reminded of this in his own phrases, can accept the referral. Along with this is the parent's fear that he is a "bad" parent. Parents are not "bad" intentionally but often in trying very hard to be extra good parents they become so anxious, over-solicitous and over-protective that they do all the things that make their child exactly the opposite of the kind of person they can be proud of. For such people, being referred to the clinic is a terrific threat. They must be reassured that they are not alone in this but that it is a mistake made by many parents and with the counseling of the Clinic Staff for the parent and therapy for his child often these behavior manifestations work themselves out to a happy conclusion.

A frequent question is: "Do I *have* to go to the clinic?" The patient should understand that he does not have to come to the clinic. It is for his own benefit that he is being referred. Often just knowing that it is not compulsory helps the patient decide to take the step in coming to the clinic. Most people like to feel that what they do is their own decision, not one forced on them by others.

"Isn't the clinic at Delaware State Hospital?" This should be anticipated for if it is not presented at the time of referral the patient finds the shock greater when it comes from the clinic social worker, who, a stranger to him, is trying to arrange his appointment. A frank explanation that while the clinic building is on the State Hospital grounds and the Mental Hygiene Staff is under the direct supervision of the Superintendent of the State Hospital, the clinic has its own staff of psychiatrists, psychologists and social workers. Its building is separated from the rest of the hospital with a separate entrance gate. If continued anxiety is expressed about coming to the hospital, it is possible to schedule an appointment in one of the traveling clinics. These are located in Wilmington, Dover and Georgetown. School children in Wilmington can be seen through the clinic at the City Board of Education.

"Will they commit me to the State Hospital?" The clinic doctors do not commit patients to the hosiptal. They can recommend either commitment or voluntary admission to the hospital if this appears indicated. Actual carrying out of the commitment is then left to the referring physician. Voluntary admission is a decision the patient can make after he has been told of the psychiatrist's recommendation. Parents who fear we may remove their children from their homes can be reassured that the Clinic does not remove children from their homes. If the psychiatrist feels the child will benefit by a period in an institution, he will recommend this. Then after the referring physician has discussed this with the child's parents and if both feel that it is in the best interest of the child they can make application for institutionalization.

Next the patient wonders: "How are ap-

pointments made?'' The referring physician sends a referral blank to the Superintendent for approval. This is then sent by him to the clinic, after which a social worker contacts a relative to secure a social history. The patient may feel that it is unnecessary to get a social history from someone else but we have found that by so doing we secure another approach to the patient's problem that further aids the psychiatrist in his own interview with the patient. Usually a parent, husband or wife is interviewed. The patient should be prepared for this as sometimes he has a preference regarding the best qualified person to supply accurate and adequate information for a background study. Here again is an opportunity for the referring physician to assist the clinic by sharing with us the name and address of the person from whom we can secure the history. The address and how to find it are especially important facts when the informant is located in the country. Time and expense are saved if directions are secured from the patient when the referral is sent in. After a history is obtained the clinic social worker arranges an appointment with the patient for the diagnostic examination which includes psychiatric and psychological tests. Two to three hours are often required for this. If the patient is a potential danger to himself or the community but is not in need of immediate hospitalization it is important that this be indicated for otherwise, patients are studied in order of the acceptance of their referral. The time between receipt of the referral and the first contact with the family varies depending on the length of the waiting list. The period of waiting will be easier for the patient to accept if he knows about it.

''What will happen to me at the clinic?'' The psychologist gives the patient several standard tests to aid in the evaluation of the patient's problem and his ability to use the help of the clinic. The psychiatrist interviews the patient and gives him a neurologic examination if this seems indicated. Children will be glad to know there will be no needles and they will not be hurt. In fact most children love the ''games'' they play with the psychologist.

In answering the next question: ''What happens after the diagnostic interview?'' I would like to add the question ''Will I know what they think is the matter with my child?'' These questions are vitally important and the answering of them is a place where the referring physician's role is most challenging. To assist in interpreting these recommendations to the patient, the clinic psychiatrist sends the referring physician the clinic findings and recommendations. The physician may then discuss these with the patient or the parents of the child referred and prepare him for acceptance of the recommendations if he is in accord with them.

The recommendations, for instance, may include psycho-therapy for an adult or play-therapy for a child, with counseling for his parent. This involves explaining to the patient that the psychiatrist feels he would be helped by continued interviews at the clinic probably on a weekly basis. For the child it means such interviews in the playroom with the psychiatrist while the parent is seeing the social worker for counseling. If the patient accepts this recommendation either the physician or the patient can call the social worker to arrange the program of therapy. Another possible recommendation might be medication which the psychiatrist would specify in the letter. Sometimes an electroencephalogram is recommended. If the patient accepts this latter recommendation it can be arranged through the Director of the Governor Bacon Health Center. A fourth recommendation might be for institutional care. Again this is an opportunity for the referring physician to discuss this with the patient and if the recommendation is accepted the doctor and the patient can make the application to the institution directly. Mental Hygiene Clinic will furnish the institution or Governor Bacon Health Center with a copy of our findings on receipt of a written request.

Should the patient want an opportunity to discuss the recommendations with the psychiatrist, an appointment can be made by contacting the social worker at the clinic. All appointments at the clinic are made in advance in order to insure for each patient the undivided attention and time he needs.

From the aforegoing article we hope you will know how very important and valuable we feel, you, the referring physicians, are to

the clinic, and how much we need your understanding of our program in order for both you and the clinic to be of utmost service to your patient.

THE ROLE OF THE PSYCHIATRIC SOCIAL WORKER IN GROUP THERAPY

HAZEL BROWNE MADRY, A.A., M.A., M.S.W.,*
Delaware City, Del.

One of the functions of the psychiatric social worker at the Governor Bacon Health Center is that of leader in group therapy. Group therapy has been used comparatively little in institutions — though it is apparent that in these settings in which upset and emotionally disturbed youngsters live together constantly, the use of such a method by people who can handle it is essential.

The difference between individual and group therapy is on the emphasis. The goal is the same; — to bring about emotional maturity, understanding and insight. Group therapy is basically a special application of the principles of individual treatment to two or more persons simultaneously. In group therapy, the psychiatric social worker uses the same methods and concepts as in generic case work.

At the Governor Bacon Health Center, as in all child guidance clinics, there is a professional team composed of psychiatrist, psychiatric social worker and psychologist. In therapy, when change in the personality is the aim, adequate diagnosis must be the center of the process. The diagnostic process at the center requires a comprehensive understanding of the situation, the child, the people of his environment, his reactions which include earlier experiences. This information is obtained by the psychiatrist, and social worker at the time of the evaluation visit. Following the evaluation interviews with the child and parents the psychiatrist and psychiatric social worker in conference review the presenting problem and the psychiatrist arrives at a tentative diagnosis. This serves as a guide to the psychiatric social worker for cottage placement following admission and assignment of therapist by the psychiatrist. Thus even before admission there is the close liaison between the psychiatrist and psychiatric social worker which continues throughout therapy. The conferences often include the psychologist who contributes to the diagnosis and the therapeutic process.

Not all persons who come for help with problems in personal and social adjustment can or should be treated in a group. We adhere to the practice of placing individuals with the same syndrome rather than the same symptoms together. Group therapy is indicated when an individual is unable to gain from individual psychotherapy. Slavson reports that a large number of "children especially, as well as some adolescents and adults require relationship in a group as an integral part of treatment. Experience also indicates that many who are socially maladjusted and suffer from a variety of personality deviations are accessible only to group treatment." The group usually consists of six to eight children of the same sex. Adult groups may contain as many as fifteen. Flexibility is a prime consideration for success in group therapy.

Slavson points out that the "chief common value of the group is that it permits acting out of instinctual drives, which is accelerated by the catalytic effect of other group members. There is less caution and greater abandon in a group where the members find support in one another and the fear of self-revelation is strikingly reduced. As a result, patients reveal their problems more easily and therapy is speeded up. Defenses are diminished and the permissiveness of the total environment and the example set by others allows each to let go with a decrease of self-protective restraint. Although groups lessen the defenses of adults, this is particularly true of children and adolescents. Free acting out and talking through yields satisfaction. At the same time it brings patients face to face with their problems quite early in treatment. The defenses against injury to one's self-esteem are also reduced. The friendly group climate and the mutual acceptance do not require one to be on the defensive. All have the same or similar problems and no negative reactions are anticipated by any one. Status is assured. There is no fear of retaliation or debasement. But release and abreaction are not enough. Therapy must find means to re-integrate the personality, reshape attitudes and give the

*Chief Psychiatric Social Worker, Governor Bacon Health Center.

individual means for dealing with his life in new ways.

The psychiatric social worker has certain qualities and attitudes essential to work with individuals or a group of persons who are emotionally disturbed. These include warmth, responsiveness, a permissiveness, and continued interest throughout the period of therapy. She knows the need of the individual for acceptance and respect no matter what he says or does. The psychiatric social worker refrains from coercion and is not judgmental. She is trained to understand and encourage the development of interpersonal relationships. The therapists encourages the patients to talk over their problems freely. She remains objective thereby permitting and encouraging full discussion of the feelings without guilt. In group therapy under her leadership children and mothers become aware that others have similar experiences and together learn how these problems which they felt were peculiarly their own may be solved. When individuals in the group express possible solutions to a problem which is agreed to by the group, the psychiatric social worker gives the encouragement necessary to make the change.

There is a reason for all behavior; and, it is the social worker's responsibility to learn why the members of her group do the things they do. She must be alert, observant, and able to listen attentively hearing with her third ear important feelings that are not expressed as well as those that are verbalized. She must have a quick perception of the emotional needs of the individuals. She must understand group relations and able to recognize the pattern of the group before her. No two groups are alike any more than two individuals.

The most important tool of the group therapist is her own personality. To be really helpful to others any one who works with people must learn to know herself, to recognize her own strengths and weaknesses. Intellectual knowledge cannot replace a disciplined learning about oneself in relation to one's work with human beings.

For successful group therapy the psychiatric social worker must know a great deal of psychology and psychiatry; and, be able to mobilize the forces which make self-help possible. She must also understand the dynamics of normality as well as of emotional disturbance. She must know the need of children and adults to release hostility or anxiety before any positive work can be done. She must understand the dynamics of group behavior; i.e. what a newcomer means in a group; what certain grouping means to the individual. She must be comfortable in a group and able to handle a group. This is not the same as handling a number of individuals. Ability to work successfully in individual therapy does not necessarily imply that the same worker will be effective in the group situation. Most group therapists have had a period of supervised field work. Only a person who has gone through this process of learning will be free to accept love, hate or resistance from the group members without becoming either conceited or discouraged or angry. The conscious use of her own personality is essential for the group therapist.

There are various types of group therapy, activity, didactic, interview or discussion, and relationship as well as manipulative which includes the personal as well as the physical environment. With one group there may be a combination of types. Activity group therapy is used most with emotionally disturbed and socially maladjusted children. Using this type the therapist allows the individual children to act out their impulses, desires, and wishes with more freedom than can be allowed in a classroom or home. As a group therapist in this situation the psychiatric social worker must have knowledge and ability to use a program as a tool. Activity is important but by itself will not help the child with serious emotional problems. While the therapist cannot help the individual child in the group without activities the program is only the means to be used to an end—to help the children with their interpersonal relationships. The effective therapists must have the ability to change quickly from one activity to another.

Adults and adolescents are able to profit by interview or discussion therapy. They discuss the subject of interest with as much freedom as their anxieties permit. Adjustment is made possible and accelerated by the group experience. The psychiatric social worker ob-

serves, records mentally and from these two operations interprets to the group. The desire on the part of the group to do something about the troublesome and conflicting relations is often strong. The group is the milieu in which individuals with similar problems work them out on a social, educational, recreational or psychological level.

Relationship therapy as differentiated from other types of psychotherapy is characterized by the fact that the therapist focuses his interpretations upon each person's attitude towards the therapist and towards the other members of the group. It is based on the principle that the patient brings into the relationship with the therapist both positive and negative emotions and patterns that he uses in his everyday life. The therapist serves a buffer thus the therapeutic relationship becomes a living experience in which the "individual is able to release the whole gamut of feelings towards the therapist." The psychiatric social worker remains passive to the content but at the same time is active in pointing out the immediate underlying emotional drives. These immediate emotions are the feelings of which the individual is nearly aware and which he can face without too much anxiety. The general purpose is to help the patient come to terms with himself. Not all persons need the same depths of therapy and the therapist must have judgment and experience so as to sense how much insight is needed by each patient. Improvement is noted when individuals begin to make adjustments in living arrangements, employment, education, hobbies and take on new interests. This may be a case of moving the square peg to the square hole.

All kinds of therapy have the same purpose which is release from intense emotional distress, a way of making more effective and more satisfying relationships with people. The requisite lies in the ability of the individual to achieve a relationship with the therapist and through her to all members of the group. The process involves leadership on the part of the psychiatric social worker which makes it possible for the group to effect acceptable changes rather than hold to ineffective ways of dealing with people. The group is the milieu in which individuals with similar problems work them out on a social, education, recreational or psychological level.

"The need of human beings for each other both emotionally and realistically lends itself to the formation of groups." It is natural for people to function in groups;—the family, the social group, class, a union or committee. Conflicting tendencies can become so intense as to make group effort completely ineffectual. Each of you in your experience has been confronted by antagonism on the part of members of the group which vitiated the opportunities for group effort; and the hostility has sometimes caused the total dissolution of the group. There are probably no distinctly different qualitative dynamic processes occurring in group therapy than in normal groups. I believe that at the Governor Bacon Health Center we are able to demonstrate through group therapy that the principles may be applied to other fields particularly education. We have learned and are learning a great deal about dynamics involved in the relationship between the group and the therapist. The more healthy the emotional status of the group the more likely the mutually satisfactory goals can be achieved. The application of these principles to collective effort should greatly increase the effectiveness and improve our opportunities in all endeavor in the future.

REFERENCE

The Practice of Group Therapy, edited by S. R. Slavson; Therapeutic Work with Children, by Gizelle Konopka; Emotional Maturity, by Leon Sauls.

Tuberculosis is second in importance among public health problems in Turkey, malaria having almost come under control. Long years of malaria control work, the application of DDT and administration of quinacrine plus health propaganda have considerably lessened the incidence of malaria, and deaths from malaria are now few. The tuberculosis death rate is 150 to 200 per hundred thousand. The rise in the cost of living, high prices for food and rent and an insufficient number of hospital beds for the tuberculous, resulting in long waiting lists, have greatly increased the spread of the disease among the lower income groups during the war years. Edit., J.A.M.A., May 5, 1951.

MEDICAL SOCIETY OF DELAWARE
Hotel DuPont
WILMINGTON, DELAWARE
MONDAY, OCT. 8, 1951

7:00 p.m.—Meeting of the Council
8:30 p.m.—Meeting of the House of Delegates

TUESDAY, OCT. 9, 1951

SCIENTIFIC SESSIONS—HOTEL DUPONT

9:30 a.m.—Invocation: Rev. William F. Dunkle, D. D.
9:40 a.m.—Address of Welcome: Hon. James F. Hearn.
10:00 a.m.—Report of House of Delegates: A M. Gehret, Wilmington
10:10 a.m.—(Color Movie): New Kidney Approach: Brice S. Vallett, Wilmington
10:20 a.m.—Diagnosis and Treatment of Epilepsy: Douglas T. Davidson, Jr., Boston.
11:00 a.m.—Exhibits
11:30 a.m.—Cranio-cerebral Injuries: Richard G. Coblentz, Baltimore.

12:30 p.m.—Luncheon: Members and Guests Medical Society of Delaware

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2:00 p.m.—Certain Aspects of Surgery of the Newborn: C. Everett Koop, Philadelphia.
2:40 p.m.—Treatment of Nephrosis: Lee E. Farr, Upton, Long Island
3:20 p.m.—Exhibits
3:50 p.m.—Treatment of Peripheral Arterial Disease: Hugh Montgomery, Philadelphia.
4:30 p.m.—Office Management of Diabetes Mellitus: Perry S. MacNeal, Philadelphia.
2-5 p.m.—State Board of Health Mobile Unit: Chest X-rays of Physicians and Their Families.

6:45 p.m.—Reception and Dinner (Subscription)
9:00 p.m.—Address: John W. Cline, San Francisco, President of the A.M.A.

WEDNESDAY, OCT. 10, 1951

9:00 a.m.—Chemicals and Health: John H. Foulger, Wilmington.
9:40 a.m.—Industry's Challenge to Medicine: R. Ralph Bresler, Philadelphia.
10:20 a.m.—Care of the Woman in the Postmenopausal Era: Franklin L. Payne, Philadelphia.
11:00 a.m.—Exhibits
11:30 a.m.—Impressions After 33 Years in Medical Practice: Charles E. Wagner, Wilmington.
12:10 p.m.—Election of President-elect (New Castle County).

12:30 p.m.—Luncheon: New Castle County Medical Society. Members, Guests and Auxiliary.

2:00 p.m.—Role of the General Practitioner in Counselling Before and After Marriage: O. Spurgeon English, Philadelphia.
2:40 p.m.—Potential Dangers from the Incomplete Examination of the Pregnant Woman: J. Robert Willson, Philadelphia.
3:20 p.m.—Exhibits
3:50 p.m.—Retrolental Fibroplasia: P. Robb McDonald, Philadelphia.
4:30 p.m.—Management of Intractable Achalasia: H. Clinton Davis, Philadelphia.

WOMAN'S AUXILIARY, M. S. of D.
Delaware Academy of Medicine
TUESDAY, OCT. 9, 1951

10:00 a.m.—Registration
10:30 a.m.—Business Session
12:30 p.m.—Luncheon: duPont Country Club
Address: E. Gilbert Ketchum, Philadelphia, Supervisor, Reeducation Clinic, Pennsylvania Hospital.
6:45 p.m.—Reception and Dinner (Subscription) Hotel duPont.
Address: John W. Cline
San Francisco
President of the A.M.A.

WEDNESDAY, OCT. 10, 1951

10:30 a.m.—Business Session
Inaugural Address: Mrs. S. W. Rennie
12:30 p.m.—Luncheon: New Castle County Medical Society, Hotel duPont.

+ Editorials +

DELAWARE STATE MEDICAL JOURNAL

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W. EDWIN BIRD, M. D. ..... Editor
822 North American Building

ANDREW M. GEHRET, M.D. ..... Associate Editor
1007 Park Place

M. A. TARUMIANZ, M. D. .....Assoc. & Managing Editor
Farnhurst, Del.

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GERIATRICS

Everything that lives must grow old. With the process of aging comes the various needs of the aged. The disabilities and diseases of the aged as well as the conservation of their health should be the interest of everyone.

The average life span in the United States in 1900 was 48 years, today it is 67 years. Forecasts estimate 75 years as an average life expectancy in 1960 in the United States. The number past 65 years of age gained 35% from 1930 to 1940 while the population of this country gained only 7.2%. The number in this particular age group in this country is about 14 million. Gradually we are becoming a nation of older people. The adequate scientific study of this period of life has been neglected. Only recently the medical schools have turned their attention to specialized study of the aged. Geriatrics deals with the health and illnesses of the aged. Gerontology is the study of the aging processes. The geriatrician will fill an important place in our community life. His task demands highly specialized training, including social and economic aspects of life. We should look at old age as one period of continuous life process. The highly specialized scientific studies that have been given to other periods of life are badly needed here.

We in Delaware have about 27,000 men and women who have passed the age of 65 years. Are we doing any research work in this field? We certainly have many wealthy citizens who have passed this age and who should be interested in establishing a foundation for the study of this problem. Our physicians should encourage their elderly patients to become interested in such a foundation.

Chronological age is not the chief determiner of usefulness. "Man is actually as old as the total functioning capacity of his vital organs."* Age must be determined biologically. Many authorities believe that mental maturity is not reached until the age of 30 and increases slowly until the age of 70. A normal person is at his best mental period between 40 and 70. Men and women of this age group should contribute to the science of gerontology thus enabling society to create a new era for the chronological aged, an era when men and women will continue their wholesome activities until the zero hour of their biological end.

*Benjamin, Harry: "Biologic Versus Chronologic Age."

MISCELLANEOUS

Doctors Incomes, 1949

Physicians in private practice in this country in 1949 had average net income before taxes of $11,058, and those in big cities didn't make as much as those in medium size communities.

These findings were reported recently on the basis of a mail survey of 55,000 physicians, by the Department of Commerce and the American Medical Association. The association, which conducted the study jointly with the department, called the study the best ever made of income in the profession.

The $11,058 for the entire profession included salaried and independent physicians, but not internes, resident physicians and teachers.

Other findings: Neurologists had the highest net average income, $28,628; 13 per cent of those in private practice had net incomes under $3,000 and eight per cent earned more than $25,000 net before taxes.

Key groups:

Neurological surgeons	$28,628
Pathologists	22,284
Gynecologists	19,283
Members of partnerships	17,722
Full specialists	15,014
Doctors paid by fee	11,858
Part specialists	11,758
General practitioners	8,835
Doctors on salary	8,272

Doctors do best in medium-sized cities (about 350,000), worst in villages under 2,500 and cities of 1,000,000 or more. Lowest-paid big-city doctors in the U .S.: New York's.

American Board of ObG.

Effective August 10th, 1951, the office of the American Board of Obstetrics and Gynecology will be located in Cleveland, Ohio. Please address all communications to:

Robert L. Faulkner, M. D.
Secretary-Treasurer
American Board of Ob. & Gyn.
2105 Adelbert Road
Cleveland 6, Ohio

New Tumor Code

The first major attempt to clarify and standardize the complicated terminology of cancer has been made by the American Cancer Society.

Publication of a new book, "Manual of Tumor Nomenclature and Coding," was announced recently by the Society. The book will be distributed to cancer clinics and registries, hospitals, health departments, medical schools, research centers, and to individual pathologists, surgeons, and statisticians.

Widespread use of the new tumor code is expected since it will be used in conjunction with the American Medical Association's "Standard Nomenclature of Diseases" and the World Health Organization's "International Statistical Classification of Diseases, Injuries and Causes of Death."

Employment of the code will result in more comprehensive statistical records since it classifies both benign and malignant tumors according to histologic origin. Heretofore most cancer death and incidence records have indicated only the body site of tumors. The final aim of statistical studies is to reflect organized knowledge back to the clinician for the patient's benefit.

Dr. M. C. Winternitz, chairman of the National Research Council's Division of Medical Sciences, called the new manual "a real contribution to the accurate analysis and exchange of cancer data."

"The study of tumors is an exacting and complex discipline," he said. "Its pursuit is difficult enough without the handicap of barriers to communication in the form of conflicting terminologies and statistical coding systems. Pathologists and statisticians now have pooled their efforts to overcome these barriers, and to provide a common language for themselves and for record librarians, practitioners, students, teachers, and research workers."

Work on the manual has been in progress since 1948 under the direction of an American Cancer Society statistics committee.

OBITUARY

GERALD L. DOUGHERTY, M. D.

Dr. Gerald L. Dougherty, a practicing physician in Wilmington for 43 years, died in the St. Francis Hospital where he was staff chief of medicine, on August 9, 1951, of heart disease, at the age of 68.

A native of Wilmington, Dr. Dougherty was born Sept. 23, 1882, a son of Mr. and Mrs. Dennis Dougherty. He attended the Wilmington public schools, the Wilmington High School, Georgetown Medical College, and in 1908 graduated at the University of Maryland School of Medicine. He served his interneship at St. Agnes Hospital, Philadelphia.

As a student in the Wilmington High School, Dr. Dougherty was a member of the school's track team and winner of a silver cup, awarded members of the winning relay team at the Penn Relays in 1901.

Dr. Dougherty was commissioned in the Army Medical Corps in World War I and previous to this service, was among the physicians who served when an influenza epidemic swept Nashville, Tenn.

A widower, the doctor had been married to the former Essaline Collins. He is survived by two sons, Gerald L. Dougherty, Jr., former University of Delaware track man, and Francis Dougherty; two daughters, Mrs. J. F. Montgomery and Mrs. Walter L. Brady; a sister, Miss Mary Dougherty, and seven grandchildren. All are Wilmington residents.

Funeral services were held at St. Ann's R. C. Church on August 14, 1951, with interment in St. Joseph's-on-the-Brandywine Cemetery.

BOOK REVIEWS

Principles of General Psychopathology. An Interpretation of the Theoretical Foundations of Psychopathological Concepts. By Siegfried Fischer, M. D., Clinical Instructor in Psychiatry, University of California, formerly Professor of Psychiatry and Neurology, University of Breslau. Pp. 327. Cloth. Price, $4.75. New York: Philosophical Library, 1950.

This book is an excellent survey of the important psychopathological phenomena. The author wisely divided this book into four parts: one dealing with the fundamentals of psychopathology; the second part deals with the psychological connections; the third with the syndromes of mental disturbances; and part four describes normal, neurotic and psychopathic personalities and the relation between personality and psychosis. The author is very careful in his interpretation of various reactions and phenomena. We sincerely recommend this book to students, psychologists, social workers and young psychiatrists. This book should be among the test books in every library.

Freud: Dictionary of Psychoanalysis. Edited by Nandor Fodor and Frank Gaynor with a Preface by Theodor Reik. Pp. 208. Cloth. Price, $3.75. New York: Philosophical Library, 1950.

This is a book that should be in every medical and public library. The editors of this Dictionary have recognized the long felt need of such; however, one should not misconstrue the purpose of this book. Such a dictionary cannot be used as a text book of psychoanalysis. The editors of this book have endeavored to eliminate the misconceptions and misrepresentations to which psychoanalysis has been subjected. We wish to congratulate the editors for this excellent dictionary and highly recommend it to all libraries.

Sexual Fear. By Edwin W. Hirsch, M. D. Attending Urologist, Englewood Hospital, Chicago. Pp. 307. Cloth. Price, $3.00. Garden City, Garden City Publishing Company, 1950.

In this book the author presents some practical and helpful measures for understanding physiological and psychological sexual fears. This is an interesting and practical book for men and women.

Master Your Mind. By Samuel Kahn, M. D. Department of Psychology and Psychiatry, Long Island University. Second Edition. Pp. 262. Cloth. Price, ... New York: Rockport Press, 1951.

This is a very useful book for students, teachers, parents and other young intelligent people, who are interested in acquiring mental efficiency. The author gives authoratative suggestions, quotes many well known and famous authors. Various chapters on memorizing, psychology on thinking and reasoning, failure and success, are well written. We recommend this book very highly, particularly for school libraries.

Psychology—Principles and Applications. By Marian East Madigan, Ph. D., Visiting Professor, Summer Sessions, University of Arizona. Pp. 403. Cloth. Price, $4.25. St. Louis: C. V. Mosby Company, 1950.

This is a very valuable text book for students. The author gives the student a short introduction to the study of psychology, describing very clearly the biological and social forces affecting human behavior. The text is divided into four units as follows: The Nature and Methods of Psychology; The Essentials of Learning; The Biological and Social Basis of Behavior and Adjustment. We wish to congratulate the author for a fine book.

Professional Adjustments. By Sister Mary Isidore Lennon, R. S. M., R. N., M. S., Director of Social Service Department, St. John's Hospital, St. Louis. Second Edition. Pp. 362. Cloth. Price, $3.50. St. Louis: C. V. Mosby Company, 1950.

The author writes this book primarily for schools in Catholic hospitals and therefore emphasizes the Catholic viewpoints. But the suggestions she offers are of universal value. The various chapters describing the needs for professional adjustments, for discipline, for religious life, for proper conduct, etc., will prepare student nurses for a more mature social life. This book should be a necessary acquisition to any school of nursing library.

Management of Obstetric Difficulties. By Paul Titus, M. D., Obstetrician and Gynecologist, St. Margaret Memorial Hospital, Pittsburg. Fourth Edition. Pp. 1046 with 446 illustrations and 9 color plates. Cloth. Price, $14.00. St. Louis: C. V. Mosby Company, 1950.

A new and probably last edition of this excellent text on obstetrics. Dr. Titus recently passed away, all too early; his goal undoubtedly being perfection—the reduction of maternal mortality to zero. The contents are well organized, and while there might be some leaning toward excess verbiage, every chapter and sub-heading is well covered.

Dr. Titus, having been the Secretary of the American Board of Obstetrics and Gynecology —thus giving his opinion additional weight— finally took the stand that some aspects of external caliper pelvimetry were obsolete. This, despite the fact that hospital examiners and inspectors felt that no obstetrical chart would be complete unless the time worn external measurements were thereon inscribed.

This reviewer agrees with Dr. Titus that excess "ironing" of the perineum at time of delivery is to be condemned. He feels, and rightly so, that this frequently causes submucous laceration and separation of the muscles which can not be detected at the time.

The following statement, on page 682, might be greeted with a raised eyebrow: "A truly 'difficult forceps delivery' is a rare event, and usually results from some error in judgment having been committed by the obstetrician . . . . . " However, after pause and honest consideration, we believe this to be only too true.

This book is an expression of the knowledge and experiences gained throughout the years by an able clinician, together with the accepted advances of other workers in the field. It is a valuable addition to the working library of any physician interested in obstetrics.

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